Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 00 **Physician** 200 ebruary /Medical give street and number 4c. County of Death 4a Facility Name (If not institution, 4b. City, Town, or Location of Death Examiner NA 3 rurp et: nove 212 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Days 1 Ø M 2 □ F 220.42. 1149 Yrs 11.30.1945 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Show 10a. State the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No BAKIMORE Director NA MD 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ŏ ROAD 21215 3914 FORTLEIGH USA ітеття 23е Funerai within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 120 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel', or 1 Yes 2 No Specify. Specify: BUACK. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Dep riment of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event. The Means injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY LABORER 1214 GRADE NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALBERT BRADFORD DAISY FRANKUN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (SISTER) 3914 FORDLEIGH BALTO. MD. BRADFORD RP. VERNET 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 03.02.06 PIKESVILLE, MD DRUID RIDGE \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNERAL SERVICE Bouc 5151 BALTO. NATE PIKE, BALTO. MD 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 900 Physician Ne DR nucle /Medical Due to (or as a consequence **Examiner** espinante Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a la consequence Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the ettending physician Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Fiternel melenter 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physicien: the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 25 No 2 this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 5 Pending investigation Injury 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a

To the Funerel C

completely filled i filled 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier wan 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month)

**ORIGINAL** 

2000.

32. Registrar's Signature

			1_ For	State of M	arylar	d / Depar	tment o			al Hygier	HHID	060	102
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	Funera		5. Social Security Number 6. S	ex 7. A			If Under 1 Y		Hrs. 8. Da	te of Birth	9. 1	Birthplace (State Country)	e or Foreign
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	eath s 23	Funeral	2730 Melrose Ave	nue 12. Was Decedent	Ever in U	S. 13. Wa		21163 of Hispanic Origin	n? (Specify Y	es or No-	US/ 14. Race - A	merican Indian	
	ter d	Š	1 ☐ Never Married 2 🕅 Marned	Armed Forces 1 ☐ Yes 2 ☑	?	If Y	res, specify	Cuban, Mexican, I	Puerto Rican,	etc.)	Btack, W	hite, etc.	
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	d be antai	o Be	William Howard					No.11	io Mar	ie Wie	rand		
1	Maryland 2 should be 1 2 nand Mentai I 7 ie marked or	To	19a. Informant's Name/Relationship (			19b. Mailing	Address (SI	treet and Number				e, Zip Code)	
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	Sattimore, bernit. Pages 1 at Department of Hea mportant: If Nem iny injury or othe		20a. Method of Disposition			Place of Disposit	tion (Name o	of	Date		Location - City		i
	baltimory permit. Pages: Department of H Important: If Ite eny injury or of		1 ⊠Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif		)	-	-	netery 3	/7/2006	5 Ow	ings Mi	11s, M	)
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			Martin D. Lav  23a. Part1. Enter the disease, or com shock, or hear failure. List only	plications that cause one cause on each	d the dear	th. Do not enter	the mode of	dying, such as ca	ardiac or resp	iratory arrest.	ial y Lan	Interval	Between
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W 5	0 50			_ 0									
7	BOX 68 (leath certificate attending phy)	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-							23d. Date of	delivery	
9 6	death death defor	icla	in the past 12 months?	1☐Live birth 4☐Pregnant a			ctopic pregr Other <i>(specif</i>				Month	Day	Year
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MARGARE	r Vital HeC ysicien: The lav is certificate has director, page 2.	Be	25. Was case referred to medical examiner?	Hospital:				Other	of Death (Che				-
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	DIVISION OT  To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	dical		nysician: To the bes									60(s)
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	S Regis	tate trar	31. Date filed (Month, Day, Year) MAR 0 1 201	100	trar's Sign	ature John	20						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** RIJIMENTHAL. ELIZABETH February 23,2006 9:10 p. /Medical 4h. City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Lutherville

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Baltimore County GENESIS ELDERCARE: BRIGHTWOOD 8. Date of Birth (Month, Day, Year) April 5,1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 27 F 89 Director Pennsylvania 217-01-3004 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location if item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic event, it a Medical Examinar must be multiled at 1 ☐ Yes 2X No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 U.S.A. 6206½ Haddon Ave. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iten eny injury or other traumatic event, the Medical Examinat one. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) Medical Artist School of Medicine 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kahler Henrietta Mark Ray Cone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6101 Birchwood Ave. Baltimore, Maryland 21214 Nancy Lewis (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green Mount Crematory 2/28/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 Mas Approximate Interval Between Onset and Death # davs 23a. Part 1. Enter the disease, or comprigations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia **Physician** days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner cete has been signed by the attending physiclen and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy 2 No 1 Yes 1 🗌 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; Algorithms of the funeral py the funeral 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06 D18410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lutherville MD Road 10755 Falls 32 Registrar's Signature 31. Date filed (Month, Day, Year) State WAR. Registrar

		1 - For State Registrar	State of Maryland		artment of H			Reg. No.	)06	06001	-}
Dhuais	ion	1. Decedent's Name (First, Middle, Last	)				2. Date of D Month	eath Day	Year	3. Time of Deat	
Physic /Med		<u>Virginia Eve Burri</u>							, 2006		P <sup>M</sup>
Exami	iner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		eath		ounty of Deat		
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arylan show	-	10a. State 10b. County	10c. City	, Town or Lo	cation					1 ☐ Yes 2 🛣	
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hin 72 hours after "natural", or Madical Exem	l by	3 ☐ Widowed 4 ሺ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		3	ipecify: Wh	nite	
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Hygie ther t	င္ပ	17. Father's Name (First, Middle, Last)		ракег	з петрег		Name (First, Midd				
Mental Hy Mental Hy arked oth	To Be	George Albert Bass	ford			Mary Ji	une Shipl	ev Ra	ssford		
shoull nd Me	F	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street						
National 2 should alith and 27 is more traum		Glenn R. Burrier,	son	5455	Stone Roa	ad, Free	derick, N	lary1a	n <b>d</b> 21	703	
S 1 a cothe		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	20b. P	lace of Dispo	osition (Name of matory or other place	ce)	Date	20c. Loca	ation - City or	Town, State	
Page nent ant: H		4 □ Donation 5 □ Other (Specify	Mt.							Maryland	
paritimore, Interview A. 12.13.0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at once.		21. Signature of Funeral Septice Licen.	s <i>e</i> e							uneral Ho	me
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F 5 5 9	by Pr	Part II. Other significant conditions of	ontnbuting to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23 <i>e</i> . Di	d tobacco us	e contribute t	o the cause of death	?
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aw require s been sign	plet						24a. W	as an topsy	24b. Were a	utopsy findings avail completion of cause	able
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DIVISION Of VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director;		29a. Certifier 1 X Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	wledge, dea	th occurred at the tr	me, date and p	lace, and due to the	ne cause(s) a	and manner a	s stated. e to the cause(s)	
To the H within 24 To the F complete	Medical	one)  29b. Signature and tithe of certifier	and manner stated.		29c. Licen					ith, Dey, Year)	
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2		30. Name and address of person who		n 23a) (Tvna	D2201	9		rebru	ary 27	, ZUUb	
10		Lloyd E. Halvorso				04, Fre	derick,	Maryla	ınd 21	702	
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15	Examin	er	12 Enchanted Hi		101	**	ings Mill		Baltim	
	<b></b>		Social Security Number 6. Se		(In yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. 1	Birthplace (State or Foreign
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	how how		10a. State 10b. County		10c. City, Town o					10d. Inside City Limits
	a-f s	cto	Md. Baltimo	re	Owin	gs Mills				1 ☐ Yes 2 X No
	計 9c 2g	Director	10e. Street and Number	II Dood In	+ 101	10f. Zip Code		10	Og. Citizen of What	Country?
	within 72 hours after death with the Maryland one. Than "natural" or items 23e or 28e-f show the Macinal Examiner must be motified at	rail	12 Enchanted Hi			21117			USA	
	tems tems	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	<ol> <li>Was Decedent of F If Yes, specify Cub.</li> </ol>	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	s afte	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	0	1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
Ö	hour tural	d b	3 Widowed 4 Divorced  15. Decedent's Edi		16a D	ecedent's Usual Occup	nation		16b. Kind of Busine	es/Industry
5	n 72	iete	(Specify only highest grad	le completed)	((	Give kind of work done fe. DO NOT use retire	during most of work	ring	rob. King of Basino	Samadatiy
2	withi ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Superviso	or		Coca Co	ola
0	Hyginather Pather Hyginather	Ö	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N		
ᆱ	id be ked of ic ev	To Be	Benjamin	E	Bond, Sr.		Edna	Μ.	Cor	negy
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. N	Mailing Address (Street 7 Cator Av	and Number or Ru	ral Route Number,	City or Town, Stat	e, Zip Code)
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Inportent: If tem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Machinal Examination unit be multified at any injury or other traumatic event, the Machinal Examination unit be multified at any injury or other traumatic event, the Machinal Examination unit be multified.		Edna Adams	Mother	91	7 Cator Av	enue, Bal	timore,	Ma. ZIZ	LO
Baltimore,	s 1 a of He item othe		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla	ce)	Date 2	20c. Location - City	or Town, State
Ĕ	Page nent c int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Mt. Zi	on Cem.	3-4-	-06	Lansdow	ne, Md.
<u>=</u>	mit. porta y inju		21. Signature of Funeral Service Licen	1 1 1 1	$\cap$	22. Name and Addre	ess of Facility	Ba	ltimore,	Md. 21202
m	perm Depa Impo any i		Sasera K.	Malte	The form	March F.	H. East	1101	E. North	Avenue
			23a Part . Enter the disease, or composite shock, or heart failure. List only of	lications that caused one cause on each lin	the eath. Do no	enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			nac Dear	th			Onset and Death
*	/Medical		re ulting in death)		consequence of)					
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as a	D E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (of as a	consequence of					
$\delta$	nd	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			nicmico	Wey.			
. 109	ate be executed hysician and the burial-transit	Ä	resulting in death) Last	Due to (or as a	consequence of)	:				
876	ate b hysic the b	licai		d						
k 68	e as	Me	IF FEMALE:	22						
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal death	3 Ectopic pregnanc	:y		23d. Date of Month	delivery Day Year
<u>.</u>	the s	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	5 Other (specify)				
P.O.	The law requires that the death certifica ate has been signed by the stlending ph page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions of	entributing to death bu	ıt not resultina in t	ne underlying cause giv	ven in Part J.	23e. Did tob	acco use contribut	e to the cause of death?
Ś	signe signe	ğ	Hyperternen,	Acrtic Va				1 🗆 Ye	is 2.21No 3[	Probably 4 Unknown
Ö	w requir been si should	Completed	17.11					240 1400	a Jah Wass	outeness findings available
Sec.	e law has t	mpi	Chrone asthrh	c overer	रादा, हो।	chay		24a. Was a autops perforn	y prior	autopsy findings available to completion of cause of n?
ᡖ	r. Th							1 ☐ Yes 2	No 10	res 22 No
<del>=</del>	Attanding Physician: The lav r death. ector: Atter this certificate has by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Ot	h	th (Check only on		
5	Phys this al dii	10	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ∐ Inpatie 28a. Date of Injur	nt 2 ER/Outp	ationt 3 DOA	4   Hursing Th		ence 6 Other (S	Specify)
5	ding After fune	ion	1 Natural 5 ☐ Pending	(Month, Day	Year) Inji	ıry Wo	ork? ]Yes 2 □No		,	
<u></u>	deat deat ctor: y the	ica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ırv - At home, farn	n, street, factory, office		28f. Location (St	reet and Number o	r Rural Route Number,
Division of Vital Records,	ne Hospital or Attandi n 24 hours after death ne Funeral Director: A bletely filled in by the fu	Certification:	4 Homicide determined	building, etc	. (Specify)	,,,,		City or Town	n, State)	
_	Hospital or 14 hours afte Funeral Dir tely filled in	ai C	29a. Certifier 12 Certifying Ph	ysician: To the best of	of my knowledge.	faith contined at the ti	ime, date and plane.	and due to the st	ausc(s) and manne	r as stated
	• Ho 24 h • Fui letely	edicai	(Check only 2 Medical Examone)	iner: On the basis of and manner sta		or investigation, in my	opinion, death occur	rred at the time, da	ate and place, and	due to the cause(s)
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	0		29c. Licen	se number	2	9d. Date signed (M	
}			> GAMAV	Vr.Co	am c	725	5062		2/27/	2006
	0,		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	uno Print)			MD 211	21
-	\		GARY A. MAN	KO WO!	750 MAI	N CT, 12	ESTER 3	TOWN,	- J J I	30
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature	8				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle, Last) Day Vaar Physician Η. FEBRUARY 24 **JACK** BEHRMAN 3:20 A 2006 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) APR.22,1918 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 □ F Days Months Hours Yrs 215-18-3220 87 MD Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ehow other traumatic event, the Mydical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ò 7920 SCOTTS LEVEL ROAD 21208 USA Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Iter 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER SPECIALTY STORE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ISRAEL BEHRMAN SOPHIE SHENKER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33 STONEHENGE CIRCLE #8 - BALTIMORE, MD 21208 JERRY FRIEDMAN / COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. ŏ 4 ☐ Donation 5 ☐ Other (Specify) HAR ZION TIFERETH ISRAEL 2/28/06 ROSEDALE MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. then 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ō Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 1 No 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Urrsing Home 5 Residence 6 Other (Specify) 1 Tygs 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Many er of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

Director: Aft d in by the fur 1 TYes 2 Accident n 24 hours after des he Funeral Directo nietely filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 30. Name and addless of person who co. IKHES Ave Bult M 21215. AN 31. Date filed (Month, Day, Year) State Registrar MAR 0 1 2006

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 - 20 - 2006 **Physician** WILLIAM COFFEY 6:22 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE BAUTIMORE GILCHRIST NA If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, ) 02-09-1 9. Birthplace (State or Foreign Country)
N. CAROUNA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 218-28-4995 80 Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD ELLICOTT 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? KORD U.S.A. 3119 21043 ()AKS 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry REAL ESTATE Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 end 2 should be Heelth and Mental BESSIE PACE HENRY COFFEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if itam 27 is 3119 The OAKS RO. ElliCOTT Cory, MD. 21043 WIFE COFFEY or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 Burial 2 □ Cremation 3 □ Removal from State 425/2006 EliCOTT CITY, MD permit. Page Department o Important: if any injury or once. ST. JOHN CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCINCES Breeze 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 BALTIMORE NAT'L PIKE. BALTO, MD. 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7105 Physician can /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Lighty that initiated events resulting in death) Last Due to (or as a consequence of): and Due to (or as a consequence of): ed by the attending physicien deteched for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that within 24 hours after deal. Within 25 hours after deal. This certificate hes been signed it on Funeral Director: After this certificate hes been signed to completely filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 3 Probably 4 ☐Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2010o 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name a d addre s of perso, who completed cause of death (list 23a) (Type, Print) . Charles S. falto Ms 2,20% Como 31. Date filed (Month, Qay, Year) 32. Registrar's Signature State 2006 0 2246 Registrar

Division of Vital Records, P.O.

		1 - State Registrar	State of Ma		rtment of Healt tificate of Dea	h and Mental H eth	ygiene 0 6	06008
Physic /Med		1. Decedent's Name (First, Middle, Las	anton			2. Date of D Month Felocul	Day Yea	3. Time of Death
Exami Funeral Director	ner	4a. Facility Name (If not institution, give Bon Se Cors F 5. Social Security Number 6. S 218-46-5382	tospital	(In yrs. last birthday) 59 Yrs.	0	ion of Death  Ce  nder 24 Hrs.   8. Date of E	4c. County of De	
pu »		Usual Residence of Decedent  10a. State 10b. County	<u> </u>	10c. City, Town or Loc				10d. Inside City Limits
ith the Marylan or 28a-f show	lirector	10e. Street and Number	4	BALTIN	10f. Zip Code		10g. Citizen of What	
ite; INIGITY INIGITY AT INITIONS OF The STAND OF THE STAN	Funeral Director	827 N. ARLING 7  11. Marital Status  1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕅 No	D If	Yes, specify Cuban, Me:	c Origin? (Specify Yes or Nican, Puerto Rican, etc.)	Black, W	merican Indian, hite, etc.
72 hours a	leted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ec (Specify only highest gra	Year or Dates:	16a, Deced	☐ Yes 2 No Spe ent's Usual Occupation kind of work done during O NOT use retired),		Specify: 16b. Kind of Busines	2LACK ss/industry
in yidii u ziza should be filed withir id Mental Hygiene, marked other than imatic avent, tra Mi	Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+	RECE	PRIONIST /54	LES lother's Name (First, Midd	HOUSING	Ĝ,
2 should be and Mental is marked of aumatic av	ToB	HERBERT CLAY  19a Informant's Name/Relationship	TON  Type, Print) SEN	19b. Mailing	g Address (Street and Nu	HELMA GIB	SON nbar, City or Town, State	a, Zip Code)
		20a. Method of Disposition  1 ★Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispos	sition (Name of atory or other place)	Date	20c. Location - City	or Town, State
permit. Page Department of important: if any injury or		21. Signal, e / f Fun ral S rvice Licer  22. Signal, e / f Fun ral S rvice Licer  23. Part 1. Enter the sease, or com-	elkera	CEDAR III	Name and Address of Milip A. Weath	ecility 2431 E. Co	WHET INDIE WER ST. al Services t	BACTO.MD
Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aCoronac	э.	o sclend	~		Interval Between Onset and Death
xecuted rand al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):				
ificate be executed g physicien and as the burial-transit	edical	l	d					
To the Hospital or Attending Physicien: The law requires that the death certifully 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Onknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	P ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of o Month	delivery Day Year
w requires that been signed be should be deta	þ	Part II. Other significant conditions of			derlying cause given in F	. 1	d tobacco use contribute	to the cause of death?  Probably 4 Munknown
idar nece ian: The law r rificate has be stor, page 2 sh	Completed		eral vas			pe 1 ☐ Yes	topsy prior to death	autopsy findings available o completion of cause of ? es 2 \sum No
Attending Physician: ir death. ector: After this certifics by the funeral director;	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day		0.11	Place of Death (Check only  Nursing Home 5 Re 28d. Describ		pacify)
or Attending fler death. Director: Aft in by the fun	Certification:	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farm, stre	M 1 ☐ Yes	28f. Location	(Street and Number or own, State)	Rural Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical Ce	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of and manner stat	examination and/or inv	occurred at the time, dai estigation, in my opinion,	te and place, and due to the death occurred at the time	ne cause(s) and manner e, date and place, and d	as stated. lue to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	Jul.		29c. License num	2183	29d. Date signed (Md	onth, Day, Year)
5		30. Name and address of person who 2000 West Ba	completed cause of de	ath (Item 23a) (Type, 13	erint) Bon Secondal Himore	, Haryla		23
Si Regis	ate trar	31. Date filed (Month, Day, Year) MAR 0 1 2	32. Applistration	2. 2	cente			
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DHMH 17 Rev 1/2001

CHRUNCY L. CAISP Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 06009 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0920 M February Chauncy L. Crisp zy 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | 09 13 43 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1DM 2DF Yrs. 103-34-7134 62 Director West Virginia Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Medical Example of most be confilled at 1 √Yes 2 No Gaithersburg Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20577 filed within 72 hours after death ! Hygiene. Funeral 8470 Meadow Green Way USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ★ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Computer Specialist 1 yr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be to nent of Health and Mental I ant: If item 27 le marked o Willie MAe Howard Charlie L. Crisp 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8470 Meadow Green Way, Gaithersburg, MD.20, 20577 Teressa B. Crisp 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State = 5 permit. Page Depertment of Important: If any Injury or Ft. Lincoln Cem. 03-03-06 Laurel, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses once. 4217 9th. St. N.W. Washington, D.C. 20011 D. Ma 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final C'hronic Obstructive PULMONADO Physician Diseak 8 AR-S resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and ched for use as the burial-transit The lew requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed pg 1 Yes 2 No 3 Probably 4 Unknown (W Completed SEIZUR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 110-de 24a Was an has page 2 autopsy performed? certificate 1 XYes 2 🗆 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 (Apparient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Leg Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Grieck unity Americal Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 DOSAL ABALL D 53317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph ABAII MIN 16220 Freterick RUAD #213 6A. therepus, MD 20877 Joseph A Ball MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 MAR 0 1

			For State Registrar		State of	Marylan		artment of rtificate o				F	Reg. No.	06	06010
1	Physici		Decedent's Name (First, I								2	Date of Dea Month 02		Year	3. Time of Death
	/Medic	al	Rupert A.	Col							10 11	02	20	06	12:15 A M
7.	Examin	er	4a. Facility Name (If not insti					4b. City, Town						unty of Oeath	
	Funeral	.00	Washington 5. Social Security Number	dven 6. S	tist Hos	pital . Age (In yrs.	last birthday)	Takon If Under 1 Ye	na I	Park If Under 2	24 Hrs. 8	Date of Birth	h	0 0	
*	Director		578-76-4387	1	<b>X</b> M 2□ F	75	Yrs.	Months Da	iys	Hours	Min.	(Month, Day 07 18	30	Jama	place (State or Foreign ntry) a1ca
	pug * .		Usual Residence of Decede  10a. State 10b. Co			10c. Cit	y, Town or Lo	ncation						1	0d. Inside City Limits
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	28e-	Director	MD Pri	ice G	eorges	1	iyattsv	10f. Zip Cod	ie				10g. Citizen	of What Cour	ntry?
	h with	O I	6305 Riggs	Road	#210			2078	33				US	SA.	
	ems .	Iner	11. Marital Status		12. Was Deced	ent Ever in U	.S. 13.	Was Decedent	of Hisp	panic Orig	in? (Specif	y Yes or No-	14.	Race - Americ Black, White,	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo	_	1 ☐ Yes 2 If Yes, Give			1 □ Yes 2 🙀		Specify:				ecify: Blad	
21215-0036	72 hours after death with the Maryland naturel, or Items 23s or 28s-1 show ulcal Exactorist the notified at	ed b		edent's Ed	Year or Dat	0S:	16a, Dece	dent's Usual Oc	cupati	ion			16b. Kind o	of Business/In	dustry
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212	d with	E O	8th.	12)	College (1-	¥01 3+7	Con	structi	on_	Work	er		Comp	anies	
nd	be file tai Hy d oth	Be	17. Father's Name (First, Mi	ddle, Last)					1			First, Middle,	Maiden Sur	mame)	
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Mai	d 2 st th and 7 ie n traun		19a. Informant's Name/Rela Velda Coley/		Type, Print)			ng Address (Str							
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Importent: it item 27 ie marked other then "naturel; or items 23a or 28e-f ehow eny injury or other traumatic event, the Medical Exercities must be not light at one.	}	20a. Method of Disposition	WILC		20b. F		osition (Name or matory or other			Dat			on - City or To	
m G	Pages ent of nt; it i		1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			late		ashingt		,	-24-0	6	Adelp	hi, MD	•
alti	partm portm y inju		21. Signature of Funeral Se			00		2. Name and Ad					_		
<u> </u>	Depa Impo eny is		1 101	nac	shall	2		217 9th						D.C. 20	0011
	Physician		23a. Part 1 (Finter the diseas shock, or heart failure. Immediate Cause (Final disease or condition	e, or com List only	plications that can one cause on each	used the deat ch line.	h. Do not ent	er the mode of	dying,	such as	cardiac or r	espiratory ar	100	Aura	Approximate Interval Between Onset and Death
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ita	ilcian: Th certificate rector, pag	BeC	25. Was case referred to me	dical		/			2	26. Place	of Death (	Check only o		162 703	2010
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Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha complately filled in by the funeral director, paga	Certification:	3 Suicide 6 □C	vestigation ould not be etermined	e 28e. Place o	of Injury - At he g, etc. (Specif	ome, farm, str (y)	M reet, factory, off		es 2 🗆 t		Location (S City or Tow		umber or Rura	al Route Number,
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	3		30. Name and address of pe	rson who	completed cause	of death (Item	n 23a) (Type,	Print)	1	^	1	V	210	1	11 -0
25	Sta	to	31. Date filed (Month, Day,	Year)	30 Ra	gistrar's Signa	ature A	V 0	Th	7	tur	/<	TOVE	1754	17050
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		-	For State State Registrar	of Maryland / Dep Ce	partment of Health	h	giene Reg. No. 0 6	06011
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
	Physicia		Helen M	· Cirillo		Month -	20 - CLC	0450 M
	/Medic Examin		la. Facility Name (If not institution, give street and		4b. City, Town, or Location		4c. County of Deeti	
	LXdIIIII	C1	(	x Center	annomis	s md.	A.A.	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year \ If Under	Br 24 Hrs. 8. Date of Birt (Month, Da	th 9. Birti	hplace (State or Foreign untry)
	Director		220-16-4326	F 87 Yrs.	Months Days Hours	Aug 2,	1918 Mai	ryland
	D ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	shor shor	5	MD Anne Arundel					1 ☐ Yes 2 ☐ No
	Ne M	ecto		Alina	polis		10- 600	71
	with t	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry ?
	s 23	era era	130 Hearne Road #510	Decedent Ever in U.S. 13	2140		USA 14. Race - Ame	ncan Indian
	ter d	'n	Arme	d Forces?	Was Decedent of Hispanic C     If Yes, specify Cuban, Mexic	an, Puerto Rican, etc.)	Black, White	
336	al', or	by	3 Widowed 4 □ Divorced Year	es 2 No , Give or Dates:	1 ☐ Yes 2 No Specif	y:	Specify: wh	ite
Š	be filed within 72 hours after death with the Maryland to Hygiene. A the Hygiene of other than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, I'm Medical Examinar must be notified at	Completed	15. Decedent's Education		edent's Usual Occupation		16b. Kind of Business/	Industry
בן ב	hin 7	pie	(Specify only highest grade completed [Specify only highest grade comp	ea) (G/ life (1-4or 5+)	re kind of work done during mo DO NOT use retired)	ost or working		
2	filed with Hygiene. other than ent, the M	Son	11 0		censed practio	cal nurse	healthca	re
פ	0 = 0 \$	Be (	17. Father's Name (First, Middle, Last)		18. Mot	her's Name (First, Middle,	Maiden Sumame)	
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Maryland 21215-0036	2 sho and is me		19a. Informant's Name/Relationship (Type, Print)		iling Address (Street and Num.			
≥ `	and salth n 27	ļ.,	Cecil Alton/son		O Laurel Ridge			
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal for	cemetery c	position (Name of rematory or other place)	Date	20c. Location - City or	Town, State
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licensee Ronald S. Hage		22. Name and Address of Fac State Anatomy altimore, MD	Board 655 W. 21201	Baltimore	Street
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<u></u>	hysic his co	ု	1 ☐ Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 DOA Other: 4 €	ursing Home 5 Resi	dence 6 Other (Spec	cify)
Division of	ding Phys	on:	27. Manner of Death 28a. I	Nate of Injury 28b. Time Month, Day Year) Injury	y Work?		how injury occurred	
<u>S</u>	ttendi death. stor: A / the fu	cati	2 Accident investigation		M 1 Tyes 2			
≥	l or Attenoration after death Director:	Certification:	determined 200.	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (: City or To:	Street and Number or Ru wn, State)	ural Route Number,
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	Hosp 24 ho Fune fely f	Medical	(Check only 2 Medical Examiner: On t	o the best of my knowledge, de he basis of examination and/or manner stated.				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificic completely filled in by the funeral director.	Mec	29b. Signature and title of gent ier	manior states.	29c. License numbe	ır	29d. Date signed (Monti	h, Day, Year)
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				course of death (Non-201)	on Print)	0-711	- 1 - 3 / 8	~ N
			30. Name and address of person who completed	Cause of death (Item 23a) (Typ	D, Dout A	3036	L, MJ 21	1419
	Sta	ite	01/	•				
	Regist		MAR 0 1 2006	32. Registrar's Signature	334			

				State of Maryland / Department of Health and M  1- For State Registrar  Certificate of Death		giene 1006	06012				
4		Physici /Medio	cal	1. Decedent's Name (First, Middle, Last)  Gladys Ruby Carter  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	2. Date of Dea Month 02	Day Year 24 2006 4c. County of Deat	3. Time of Death				
		Examir Funeral Director	ier	Harford Memorial Hospital  5. Social Security Number  6. Sex 1 Months Days Hours Min.  1 M 2 N F 92  Havre de Grace  Havre de Grace  1 Under 1 Year   If Under 24 Hrs.    Months Days Hours Min.	8. Date of Birth (Month, Day 01/30/1	Harford 9. Birt Co	nplace (State or Foreign untry) aryland				
		with the Maryland a or 28s-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Harford Street			10d. Inside City Limits 1 ☐ Yes 2√2 No				
DrhDesai	21215-0036	72 hours after death "natural", or iteme 23 officel Exeminatinational	Completed by Funeral Dire	10e. Street and Number  3124 Old Scarboro Road  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 XWidowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  10f. Zip Code  21154  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto  1 Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of works)  16b. Do NOT use retired)	ecify Yes or No- Rican, etc.)	Specify:	ncan Indian, a, atc. ite				
Dry	and 212	2 should be filed within and Mental Hygiene. is marked othar than eumatic event, the Ms	Be	5 Homemaking  17. Father's Name (First, Middle, Last) 18. Mother's Name		Own Home Maiden Sumame)  n Blakley					
505	Baltimore, Maryland	permit. Peges 1 and 2 should Department of Health and Men Importent: if item 27 is marke any injury or other treumatic QDGB.	To	19a. Informant's Name/Relationship (Type, Print)  Anna G. Lewis (daughter)  20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  19b. Mailing Address (Street and Number or Rural  3124 Old Scarboro Roa  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fork United Meth. Ch. Cem. 02/2	ad — str Date 7/2006	r. City or Town, State, 2 ceet, Maryla 20c. Location · City or Fork, Mary	and 21154 Town, State				
3-3406	8760, C	Medical Examiner	Ilcal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  11750 Belair Road – Kingsville, Maryland  Appropriate in the mode of dying, such as cardiac or respiratory arrest, intervious consequence of line in the mode of dying, such as cardiac or respiratory arrest, intervious consequence of line in the mode of dying, such as cardiac or respiratory arrest, intervious consequence of line in the mode of dying, such as cardiac or respiratory arrest, intervious consequence of line in the mode of dying, such as cardiac or respiratory arrest, intervious consequence of line in the mode of dying, such as cardiac or respiratory arrest, intervious consequence of line in the mode of dying, such as cardiac or respiratory arrest, intervious cardiac or respirato							
77	O. Box 6	the death certifica / the attending pt ched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deli Month	Day Year				
6	cords, P.	Attending Physicien: The law requires that the death cleath. sctor: After this certificate has been signed by the attency the funeral director, page 2 should be deteched for	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Denewha		bacco use contribute to					
ナロト	/ital Re	sicien: The lar certificete has rector, page 2	Be	25. Was case referred to medical examiner?	autop perfor 1 Yes	med? death? 2 ☑ No 1 ☐ Yes	completion of cause of				
Carte	Division of Vital Records	To the Hospitel or Attending Physicien: The within 24 hours efter death. To the Funeral Diractor: After this certificete his completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1	28d. Describe h	ence 6 Other (Spec					
	Div	To the Hospitel or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the		4 Homicide determined 256. Place of thiptry: At nome, farm, street, factory, office building, etc. (Specify)  29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	City or Tow	Ause(s) and manner as	Stated				
	<b>.</b>	To the Howithin 24 To the Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurring and manner stated.  29b. Signature and title of certifier  Physician D0627		29d. Date signed (Mont)	n, Day, Year)				
		0		30. Name and address of per in who completed cause of death (Item 23a) (Type, Print)  500 Upper Chesperk Dajve, Bel A	- 1						
		Sta Registi		31. Date filed (Month, Day, Year)  MAR 0 1 2006  32. Registrar's Signature	<del>/</del>		,				

			1 - State of Registrar	Maryland / I		ent of H		d Mei		ene 006	06013
			Decedent's Name (First, Middle, Last)					2.	Date of Death		3. Time of Death
	Physici /Medio		JOHN NORRI	s co	NNER				Month C	2004 2004	1627 M
	Examir		4a. Fecility Name (If not institution, give street and nun	nber)	4b.	City, Town, or	Location of De	eath		4c. County of Death	**
			Feninsula Regional Madica	Center		5	allsking	1		NIC	MICO
	Funeral Director		213-24-0662 ¹໘м 2□F	7. Age (In yrs. last bii 76		nder 1 Year oths Days	If Under 2.4 H	din.	Date of Birth (Month, Day, ) INE 29,		place (State or Foreign intry) yland
	and		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location						10d. Inside City Limits
	Mary f •hc	Ö	Maryland Somerset				Crisfie	าล			1 ☐ Yes 2 XNo
	288 Pool	Director	10e. Street and Number		10	f. Zip Code	TISTIE	:IG	10	g. Citizen of What Co	intry?
	h witi		26508 Mariners Road				21817	7		USA	
	dea	Funerai		dent Ever in U.S.	13. Was D	ecedent of His	spanic Origin?	(Specify	Yes or No-	14. Race - Amer	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Itam 27 is marked other then "naturel", or Items 23s or 28s-f show eny injury or other traumatic event, I'm Medical Examinar must be notified at once.	Ď		2□No 1946-		es 2⊠ No	Specify:	2010 / 110	ari, otc.)	Black, White	White
Ģ	72 ho	Completed	15. Decedent's Education		. Decedent's	Usual Occupa	tion		16	6b. Kind of Business/l	ndustry
7	thin 7	npie	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	4or 5+)	life. DO NO	OT use retired)	uning most of	working			
7	ygien ygien t, th	S	7			Vaterma				Seafo	<u></u>
and E	be fill H d off	Be	17. Father's Name (First, Middle, Last)					,		aiden Sumame)	
ž	hould d Mer mark	ဥ	Aaron Joseph Conner  19a. Informant's Name/Relationship (Type, Print)	100	Maille - Ada	1 (0			en Huds	SON City or Town, State, Z	
<u>s</u>	d2s than than traut	1.5			-						,,
ā,	Heel Heel tam 2		Nancy Hernandez (Daughte: 20a. Method of Disposition	20b. Place o	f Disposition	(Name of		n St Date		Maryland :	
Ë	Pages ent of nt: # i		1 ♥ Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	otate		or other place orial Par	· .	/200	6 0	cisfield,	Mareland
altimore,	mit. I pertm sorter f Injur		21. Signature of Funer   Serve   11 nsee	Day H	22. Nam	e and Address	s of Facility				daryrand
m	Depermine trapo eny ir	1	Mary/Beth Bradshaw-P	ruitt					eral Ho	ome <del>Ld, MD 218</del>	17
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do	not enter the	mode of dying	, such as card	diac or re	spiratory arres	it.	Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	ute du	mnh	obla	etic o	Leu	kemi.	<u> </u>	Onset and Death
	/Medical Examiner		resulting in death)  Due to (o	or as a consequence		-					
	-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	or as a consequence	of):						
V	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c.								
58760,	be exicien a		Due to (c	or as a consequence	of):						
387		dicai	d								
_	leath certific ettending p I for use as	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes	ome of pregnancy						23d. Date of deliv	erv
P.O. Box	death	Physician/M	in the past 12 months?  1  Yes 2 No 4 Pregna	th 2 ☐ Fetal death int at time of death		ic pregnancy r (specify)				Month	Day Year
o.	at the d by the etach	Phy	э 🗆 Опкломп								
ds,	n requires that the de been signed by the should be detached	Ď	Part II. Other significant conditions contributing to de-	ath but not resulting in	n the underlyi	ng cause giver	n in Part I.			cco use contribute to 2 ☐ No 3 ☐ Pro	
Ö	w requ	etec						-	24a. Was an		
Division of Vital Records,	or Attending Physician: The law requires that the death certifute death.  Director: Atter this certificate has been signed by the ettending in by the funeral director, page 2 should be detached for use at	Completed						-	autopsy	prior to co	opsy findings available ompletion of cause of
<u>a</u>	intifica ctor, p	BeC	25. Was case referred to medical	-			26. Place of D	Death (C	1☐ Yes 25 heck only one)	YNo 1 □ Yes	2 No
<u>&gt;</u>	hysic his ce i dire	70.			itpatient 3	DOA Other	4 Nursing	g Home	5 Residence	ce 6 □Other (Speci	(y)
Ē	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month	Injury 28b. 7 Day Year)	Time of njury	28c. Injury Work		28d.	Describe how	injury occurred	
<u>s</u>	r Attending P er death. rector: After t i by the funera	cat	2 Accident investigation 3 Suicide 6 Could not be	dia	М		es 2 □No				
<u>≥</u>	s effer bi Direct	Certification:	4 Homicide determined	of Injury - At home, fa g, etc. <i>(Specify)</i>	irm, street, ta	стогу, опісе		281.	City or Town,	et and Number or Rur State)	al Houte Number,
	To the Hospital or Attend within 24 hours efter deatl To the Funerel Director: completely filled in by the	Medicai (	29a. Certifier 1 Certifying Physicien: To the la (Check only one) 1 Medical Examiner: On the baland mann	sis of examination an	d/or investiga	ition, in my opi	nion, death oc	ccurred a	t the time, date	se(s) and manner as s e and place, and due t	stated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	) , ,,		29c. License	number		29d	I. Date signed (Month,	Day, Year)
			I tour 13 / Ch	1) MM		D00	14314	5	1	Fcb. 27,	200 6
	6		30 Name and address of person who completed cause PANPITP IKLUU 145	of death (Item 23a)	(Type, Print)	not 8	alista	vv	am	21801	
	Sta	_	31. Date filed (Month, Day, Year) 32. Fe	gistrar's Signature	Acarl	1		- 12	4 5		
	Registr	ar	WINE O T COOD SOME	State State	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2006 2. Date of Death 3. Time of Death - Month Physician Deborah Ann Claggett 2000 ebruary 27 12:25 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Sincu Baltimore Hospital Cit 6. If Under 1 Year | II Under 24 Hrs. 7. Age (In yrs. last birthday) 55 Yrs. 8. Date of Birth 3-15-50 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 217-50-4360 1 □ M 2**X**X Director MI Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-fahow r than "natural, or itema 23a or 28a-f ahov tra Medical Examinar must be notified at MD Baltimore 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3808 Grantley Ave. 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XXVever Married 2 Married Maryland 21215-0036 1 Yes 2XXIo Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) 9 th College (1-4or 5+) Unemployeds 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be f h and Mental h John Wilburn Muriel Catherine Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: if itam 27 is Tavon Claggett 3808 Grantley Ave. Balto.MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ö Department o Important: if any injury or once. Bayview Crem. 3-3-06 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD 22. Name and Address of Facility Wesley Chavis, JR. FH 21. Signature of Fundral Service License 2007 Eastern Ave. Balto. MD 21231 Wesley 23a. Part1. Enter the objects, or complicate shock, or heart briure. List only one care tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death whe metabolic **Physician** Idau /Medical Due to (or as a consequence ol) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence ol): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate hes b Irector, page 2 si autopsy performed? res 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ٩ funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI win wad with RES - 000 February 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROMIL WADHAWAN, MD SINAL HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State MAR O Registrar 2006

(Children

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ° Physician 28, 2006 COLE N. February 8:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Commons Baltimore Catonsville 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 ☐ M 2 🖾 F 213-32-0924 Director 98 1908 Usual Residence of Decedent death with the Maryland show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 ie marked other than "natural", or Items 23a or 28a-f shov other treumatic event, "Le Medical Examinat must ke notifical at 1 ☐ Yes 2 ☑ No Funeral Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1002 Beechfield Avenue 21229 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes. Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be be if Health and Mental. Item 27 ie marked o William F. Bauer Pages 1 and 2 should Mary Florence Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle Ruth Schwab, Daughter 102 South Hilltop Rd., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State cartment of H cortent: If Ite rinjury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery Mar. 3,2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. Ħ. 21. Signature of Funeral Service Livenses Der n Der a Impo any ir 1630 Edmondson Ave., Catonsville, MD 21228 23a. Part1. Enter the disease, we shock, or heart failure. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physiclan/Medical Examiner Due to for as a consequence of the death certificate be executed burial-transit CAD and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months? Jo Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 donknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 1 Yes 2 1 No or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place Death (Check only one) Hospital: Other: 4 Voluming Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death. 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the

State Registrar

29b. Signature and title of certifier



3694

29d. Date signed (Month, Day, Year)

8,2006

and address of person who completed cause of death (Item 23a) (Type, Print) Frederick 1629

Rd. Caturille no 2/228

31. Date filed (Month, Day, Year) 32 Registrar's Signature 0 2006

Amend item#2,3,permD, CS3,3/13/06 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death -242006 CIARTER **Physician** Month WEPTANOMAH /Medical Baltimore Examiner + 5. Social Security Number 159-30-95 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign **Funeral** Days 1 □ M 2 1 F Hours 951 68 ORK Director 04/15/1 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-1 show r than "natural", or Iteme 23a or 28a-1 shov the Medical Exerciser must be notified at BALTIMORE 1 Yes 2 No Director tomore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7909 STURBURST DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Blac δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Business College (1-4or 5+) iges 1 and 2 should be filed within it of Heelth and Mental Hygiane.

If Item 27 is marked other than 'or other traumatic event, Ita Na Elementary/Secondary (0-12) ator . Father's Name (First, Middle, Last Mother's Name (First, Middle, Main Be 19b. Mailing Address (Street and permit. Pages 1 and Depertment of Heelth Important: if item 27 eny injury or other tr Baltimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature o Fune al Service tricensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DUR YPG /Medical Examiner G9116 12da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) ed by the ettending physician deteched for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown signed by t d be detech Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 🛂 📉 6 3 Probably 4 Unknown certificate hes been si rector, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2□ No 1 Yes 2 No of Vital To the Hospital or Attending Physicien: within 24 hours after death.
To the Funerei Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner Hospital: Other: 2000 2 1 ☐ Yes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 016285 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 02/27/06 ed cause of death (Item 23a) (Type, Print) 1838 GREENE TREE RD, 5 300 30. Name and address of person with ETER DR052 Ci BULLTO, UTT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 Registrar 2006

DHMH 17 Rev 1/2001

Registrar

Amend item#10a-c,10e-f perInf C855.5/22/06 TT State of Maryland Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EMBRUARY 27, 2006 **Physician** 5:47F M Alice Ruth Dickie /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth August 1997 41920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Ash Pand, New York **Funeral** 1 ☐ M 2 ☑ F 85 122 12 4792 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 28s-f ehow traumatic event, the Medical Examiner must be notified at Belcomp 1 ☐ Yes 2 X No Director Harford Maryland 10e. Street and Number 64 Raydon Rd. Extension 10f. Zip Code 10g. Citizen of What Country? 1212 Brice Square USA 03909 items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 🖾 No ģ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traumatic arons. Elementary/Secondary (0-12) General Electric Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alice Clark Kenneth Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Brice Square Belcamp, Maryland 21017 Marilou Yost 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. February 28 2006 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc. Mocki 1 /401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 9 DAYS 23a. Part1. Enter the disease, or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician NON- Q- WAVE ACUTE MYOCARDIAL /Medical Due to (or as a consequence of) Examiner INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit TYPE 2 DIABETES MELITIS Due to (or as a consequence of): P.O. Box 68760 attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4☐ Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital c within 24 hours af To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) av D25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 ILIA CEBALLOS 7601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar South. 2006

**ORIGINAL** 

	1 - For State Registrar	State of Ma	aryland / Depa	artment of H rtificate of			jiene leg. No.	16	06020
Physician	Decedent's Name (First, Mid John	dle, Last)	Demc	hak		2. Date of Dea Month Februar		2006	3. Time of Death 11:30 A M
/Medical Examiner	4a. Facility Name (If not institut		Dellic		r Location of Death	<u> </u>	4c. County		11.30 A
LXammer	Baltimore Wash		1 Center	Glen Bu			Anne A		el
Funeral Director	5. Social Security Number 192-01-3569	6. Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day May 28	1914	9. Birthp Cour Penr	place (State or Foreign ntry) NSylvania
Mo to	Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. City, Town or Lo	ocation				1	Od. Inside City Limits
Department of realth and Mental rivglene. Important: If item 27 is marked other them "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Maryland Anne	Arundel	Glen Bur	nie 					1 ☐ Yes 2 🕍 No
3a or 2 if be no	10e. Street and Number 7900 Bene	sch Circle Ap	t 755	10f. Zip Code 21060		1	Og. Citizen of USA		ntry?
remark Inere	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S	pecify Yes or No-	14. Rac	ce - Americ	
event, the Medical Exeminer must be notified  Be Completed by Funeral Director	1 Never Married 2 Mi 3XXVidowed 4 Divorce	arried 1 ☐ Yes 2 ☐ N	lo i	1 ☐ Yes 2 🛣 No	Specify:	5 1	Specif		
dical	15. Decede (Specify only high	ent's Education est grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	eation during most of wor	king	16b. Kind of B	usiness/In	dustry
the Me	Elementary/Secondary (0-12	College (1-4or 5		ail carri			Posta	1 Ser	rvice
Be C	17. Father's Name (First, Middle		Domobale			ne (First, Middle, I		•	<del></del> -
matic a	John 19a. Informant's Name/Relation	Joseph	Demchak 19b Mailie	ng Address (Street	Anna	ral Pouto Number		nown	Code
ar trau	John T Demchak	son		Dales Wa					(0000)
or oth	20a. Method of Disposition 1    Burial 2 □ Cremation	3 ☐Removal from State	20b. Place of Dispo				20c. Location		own, State
njury	4 □ Donation 5 □ Other  21. Signature of Fuperal Service	1	St Marvs	Cemetery 2. Name and Addre			Rosstra		
eny i	Musale 0	U St. M.	A North	111 Mt Ro	3	tallings	Funera	1 Horr	ne P.A.
	23a. Part . Enter the disease, shock, or heart failure. Li	or amplications that caused st only one cause on each lin							Approximate Interval Between
cian	Immediate Cause (Final disease or condition resulting in death)		osis						Onset and Death
ical iner			a consequence of): Cubitus Ul	20%					
ne i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		nousednaues of).	Jei					
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):					-4	
lcal E		d							
Medi	IF FEMALE:								
be detached for use as it by Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)				te of delive onth	ery Day Year
physi	9 🗆 Unknown	9□ Unknown							
should be detached for use as the buriat-transit leted by Physician/Medical Examir	Part II. Other significant condi	tions contributing to death but al failure, no					oacco use cont es 2 □ No	tribute to th	ably 4 NUnknown
shoul	acute ren	allarine, no	THECKLICH	ni-nazhiia	gra	24a. Was a	n 24h	Were auto	ney findings available
page 2 should						autops perform	ned?	prior to cor death? 1  Yes	inpletion of cause of
rector, pag	25. Was case referred to medic examiner?					th (Check only on		103	20140
ral dire	1 ☐ Yes 2 No 27. Magner of Death	Hospital: 1 Inpatier			4   Nursing H	ome 5 Reside			1)
e fune atlor	1 Natural 5 Pend	28a. Da e of Injur ing (Month, Day tigation	Year) Injury	Wor	k?` Yes 2 □No	253. 50301150110	w anjusy occur	.60	
ed in by the funera Certification;	3 Suicide 6 Coul 4 Homicide deter	not be 28e. Place of Inju building, etc	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Numb n, State)	er or Rura	l Route Number,
	29a. Certifier Certify	ing Physician: To the best of Examinar: On the basis of	f my knowledge, death	occurred at the tin	ne, date and place,	and due to the ca	ause(s) and ma	anner as st	ated.
o the Fune ompletely fii Medical	one) 29b. Signature and title of certif	and manner stat	led.	29c. License			9d. Date signe		
8	<b>)</b>	A/1			958	6	1/20/1	35	
2	30. Name and address or rso	n o pleted cause of de	ath (Item 23a) (Type,		550	10	708/1		
)	Dr Daljee	Sidhu 208 Cr	ain Hwy. G	alen Burn	ie MD 210	161			
State Registrar	31. Date filed (Month, Day, Yea MAR 0 1	4.9	r's Signature	afe					

		•	1 - For Stete Registrar	State of Marylan		artment of H <i>tificate of L</i>			ene () () ( . No.	5 0	16021
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month			3. Time of Death
	Physici /Medio		Rosemaria	Di Piet	50		1	Februa		2006 2006	522 PM
	Examin Funeral Director	er	5. Social Security Number 6. Sec	Street and number)  GOOD TO	2	4b. City, Town, or If Under 1 Year Months Days	Location of Death	8. Date of Birth	4c. County of	Death	ce (State or Foreign
	ט		Usual Residence of Decedent	140.00							
	Maryla a-f shov	ctor	Maryland Baltimo		y, Town or Lo Catons \					10d	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the	Olre	10e. Street and Number			10f. Zip Code		10g	. Citizen of Wh	at Country	y?
	s 23a	ral	709 Maiden Choic				21228		USA		
036	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. If a Medical Examiner must be notified at angles.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	31	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2☐xNo	ispanic Origin? (Spec in, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Black, Specify:	White, etc	C.
21215-0036	ithin 72 ho ne. nan "natur Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of workin d)	g 16	b. Kind of Busin		
22	iled w Hygier ther th	Co	12. Father's Name (First, Middle, Last)	4			nurse	/Fire & & Sindalla & San	:d-a ()		spital
and	d be t	To Be	Albert	J. Mi	iller		18. Mother's Name Dorot		den Sumame)		veland
Maryland	shoul ind Me s mark	Ĕ	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street a	and Number or Rural	Route Number, C	ity or Town, St		
	and 2 saith a n 27 L		Maria Palewicz	daughter			Ct. Baltir	nore MD	21226		
Baltimore,	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ F	emoval from State	emetery, cren	sition (Name of natory or other plac	(9)		c. Location - Ci	•	
Ē	it. Pa rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signatute of Funeral 5e → Livins				etery Feb.				
Ba	Depa Impo any I		ZI. Signature on uneral services	2	22	Name and Addres	500	allings F			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cation that caused the death	n. Do not ente	er the mode of dying	untain Roa g, such as cardiac or	respiratory arrest	na MD 2	A	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	Amyotro						0	Onset and Death
	/Medical Examiner		resulting in death)	Due to (of a a consequ	uence of):	- 10191					· · · · · ·
		e	if any leading to immediate	)	uence of):						
<b>W</b>	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Š,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
68760,	ficate t physic s the b	edlcal		I							
O. Box	The law requires that the death certificate has been signed by the ettending lage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		day Year
rds, P.	w requires that been signed to should be deta	by	Part II. Other significant conditions con	ntributing to death but not resu	alting in the un	nderlying cause give	en in Part I.		cco use contribu		cause of death?
Division of Vital Record		Completed						24a. Was an autopsy performe	d? dea	or to comp ath?	y findings available pletion of cause of No
<u> </u>	slcian certiti irector	Be c	25. Was case referred to medical examiner?	lospital:		Othe	26. Place of Death				
O	Attending Physician: or death. ector: After this certition by the funeral director, i	n: To	1 ☐ Yes 2 Z No	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury	at Nursing Hom	e 5 Residence 8d. Describe how			
ion	ttending death. stor: Aft	atlo	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	Worl M 1□'	K? Yes 2 □ No				
Divis	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After this completely tilled in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	2	8f. Location (Stree City or Town, S		or Rural R	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely tilled in by	ledical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my knowner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place, as pinion, death occurre	nd due to the caus d at the time, date	e(s) and mann and place, and	er as state d due to th	ed. ne cause(s)
	To To	Σ	29b. Signature and title of certifier		10	29c. License	e number	29d	Date signed (I	Month, Da	ıy, Year)
	1		My my mico	$\sim$	CAK	D 30	2989	Fo	bruar	y Z	5 2006
	6			mpleted cause of death (Item		BVILLE	MD	21228		O	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signal	hire			NINN			
	Registr	ar	MAR 0 1 2006	Maries S.	Joan						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year eloris, Deshazo 9:30 AM -eb 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 218-44-1812 Days 1□ M 2 F 62 Yrs Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Modical Exercities is 1 Yes 2 No Director more 10g. Citizen of What Country? 10e. Stre and Number 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done duling life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ng most of working and Mental Hygiene. Elementary/Secondary (0-12) llege (1-4or 5+) Hather's Name (First, Middle, Last) 12 should be fi and Mental H Be From, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trac soter 20a. Method of Disposition

1 Surial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myo cardial

Due to (or as a consequence of): Intarction unknown disease or condition resulting in death) /Medical Examiner unknown gestive leart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Regurgitation Mitral unknown Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ó Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9□ Unknown 9 Unknown Ā signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200.No , page certificate 2□ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3 DOA 2 1 Tes 1 🗌 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) funeral Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Diractor: After Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide within 24 hours a To the Funeral D Extertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BEEK

Registrar DHMH 17 Rev 1/2001

State

university

32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ecic

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200

H: roko

31. Date filed (Month, Day, Year)

P16629

Nary land

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Month Day Yeer **Physician** ) a o 27, 2006 /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner tell. 1) 1 esus If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year, If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 6 Sex **Funeral** Days Months 1 □ M 2 □ X F 86 Vietnam Jan. 1,1920 Director 212-94-8151 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth end Mental Hygiene. Important: if Item 27 is marked other than "netural; or Items 23a or 28a-f show any injury or other traumetic event, it is Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 1 No Director Marriottsville MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 21104 Funeral 1945 Victory Hill Way 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0020 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Vietnamese 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Lest) Be ٥ unknown unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1945 Victory Hill Way, Marriottsville, MD 21104 Pham Thi Huynh Daughter 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/3/06 Baltimore, MD Lorraine Park Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 11824 Reisterstown Road Uns Reisterstown, MD 21136 Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of): Examiner and ren ig physicien end as the burial-transit or Attending Physicien: The law requires that the death certificete be exacuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Borre Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s hes 2 10 No 1 ☐ Yes 2 ☐ No 1 TYes certificate After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Surviving Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural efter death.

Director: Aft
d in by the fur 1 Tes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled Hospital 1 Certifying Physiclan: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 5 = 9629 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EDWARDS ARLENE ARY 25, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** SEVERNA HARK ERIN GARTH If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 ☐ M 2 🖫 F Yrs. UNKNOW Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f ahow Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ERIN 1.5.A. Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WhITE þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed other then "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 2433 BALTIMORE, MARYLAND. 21203 Important: If itam 27 is any injury or other trai 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20c. Location - City or Town, State 3 □Removal from State 4 □Donation ANATOMY GIFTS REDISTRI 5 Other (Specify) 22. Name and Addr ss of Facility
Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 P rt1. Enter the diseas a shock, or heart failure. List Approximate Interval Between Onset and Death iteations that are sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Months **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performe 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo 2 ER/Outpatient 2 1 Inpatient 3 DOA 4 ☐ Nursing Home 5 XHesidence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Diractor: After 1 Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours To tha Funaral 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ish Man 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 1 2006 Registrar

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Draper Fleming 10:00 PM 2006 /Medical 4a, Facility Name (If not institution, give street and number) Lorien NWSing & Rehabi Howard 4b. City, Town, or Location of Death Examiner Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number Sex 1□ M 20 **Funeral** Hours 229-12-0713 Virginia 05 - 01: Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Itema 23a or 28a-f show th and Mantal Hygiene. 27 ie marked other then "naturel", or ttema 23a or 28a-f shov traumatic event, the Medical Exame ar must be notified at Columbia 1 Yes No Howard Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? U.S. CResident Thunderhill 21045 . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MO 21045 permit. Pages 1 and 2: Department of Health ar Important: If Item 27 ie eny injury or other trau 2008. 20c, Location - City or Town, State
Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 3 ☐Removal from State Burial 2 Cremation 4 Donation 5 □ Other (Specify) Vaugha C. Greene Funeral Sics 21. Signature of Funeral Service Licen Batto, MD 2122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
On Lan Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 24 No 1 Yes To the Hospital or Attending Physician: After this certifice funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 NO 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 🗌 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO05315D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shaw NA CH G UPTA 9 9650 SANTIAGOROAD ShAWNALA 31. Date filed (Month) Par 32. Registrar's Signature State Registrar

ORIGINAL

		1	For State Registrar	State	of Marylan	id / Depa	artment of F	Health and I <i>Death</i>		jiene leg. No.	106	060	26
	TIPE,	3	Decedent's Name (First, Middle	e, Last)		· · · · · · · · · · · · · · · · · · ·			2. Date of Dea Month	ith Day	Year	3. Time of	Death
	Physicia		John Oscar From	nm					Februar	,		1:15	A <sup>M</sup>
),	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, o	or Location of Deat	h	4c. C	ounty of Death		
1.30		0.5%	Glade Valley Nu	rsing Ho				ille			derick		
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday,		If Under 24 Hrs.	(Month, Day	/, Year)	Cou	place (State or ntry)	-
:10	Director		178-10-6241	1 <u>M</u> M 2UF	93	Yrs.			Nov. 1.	3, 19	12 Penn	nsylvan	ia
7	<b>₹</b> 10,55	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or L	ocation					10d. Inside Cit	y Limits
2	o h	5				1 2 - 1						1 ☐ Yes	2 <b>X</b> No
3	289-6	Directo	Maryland Freder  10e. Street and Number	cick	Frec	lerick	10f. Zip Code			10g. Citize	on of What Cou	intry?	
4	P of			N			21702		1,	ITC A			
4	na 23	era	8103 Glendale I	12. Was De	cedent Ever in U	.S. 13.	Was Decedent of I	Hispanic Origin? (S	pecify Yes or No-	USA 14	. Race - Ameri		
, T	re ra	Funerai	1 ☐ Never Married 2 Marri	ned 1 X Yes	2 🗀 No			oan, Mexican, Puer	to Rican, etc.)		Black, White	, etc.	
9	al',	Ď	3 Widowed 4 Divorced	If Yes, C Year or	Dates: 1936	-60	1 ☐ Yes 2 X No	Specify:		3	Specify: Whi	te	
	natur lical	Completed	15. Deceden	it's Education	i)	(Give	edent's Usual Occu	during most of wo	rking	16b. Kind	d of Business/Ir	ndustry	
21		npie	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use retire	,					
2	ygien yar th	Cor		)	2	Leute	nant Colo		me (First, Middle,		d State	es Army	
Maryland 21215-0036	d oth	Be	17. Father's Name (First, Middle,	Last)							arramo,		
7 3	and Mental Hygiene. Is marked other than "natural", or itama 23a or 28a-f show aumatic event, if a Medical Examinar must be notified at	မှ	Clarence Fromm  19a. Informant's Name/Relations	his (Time Driet)		10h Mail	ling Address (Stree		11 Peter:		Town State Zi	in Code)	
	h and 7 is n traun												
	of Health and Menta fitem 27 is marked r other traumatic e		Gregory Fromm,  20a. Method of Disposition	son	20b. I	Place of Disp	Glendale osition (Name of	-	Date	20c. Loc	ation - City or T	own, State	
altimore,	nent of l		1 X Burial 2 ☐ Cremation		n State	-	matory or other pla		5/2006	. 1 - 1 - 4 - 1	n + + on	Winds	i o
	niury		4 Donation 5 Other (S		ALT		Nationa 22. Name and Addr						
Ba	Department (important: If any injury or once.		Nugue 14.	Dugar	м(		106 East						
	19.77		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications tha	t caused the dea	th. Do not er	nter the mode of dy	ing, such as cardia	c or respiratory ai	rest,		Approximat Interval Bet	Θ
1	. X		fmmediate Cause (Final									Onset and I	
	hysician /Medical		disease or condition resulting in death)		ebrovaso		Stroke					4 days	
E	Examiner												
	===	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conse	quence of):							
V	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or infury that initiated events resulting in death) Last	c	o (or as a conse	quence of):							
8760,	cien a	E			0 (01 43 4 0011301	quorioo oi).							
87	physi physi s the t	Physician/Medicai		d									
9 x e	oding rse as	/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregr					2:	3d. Date of deli	very	
Вох	that the death certific ed by the attending p detached for use as	ciar	in the past 12 months?	4□Pre	e birth 2 🗆 Fet grant at time of		☐ Ectopic pregnand ☐ Other (specify)	cy			Month	Day	Year
P.O.	by the	hysi	9 ☐ Unknown	9□ Uni	known								
ر. ت	es that igned to be det	by P	Part II. Other significant conditi	ions contributing to	death but not re	sulting in the	underlying cause g	iven in Part I.			e contribute to		
ğ	w require been sig should b	ed	Hypertention						1 🗆 '	Yes 2E	No 3□Pro	obably 4 🗆	Unknown
000	law requas been 2 should	Completed							24a. Was	DSV		topsy findings completion of a	available ause of
œ .	The lavate has	E							perfo	rmed?	death? 1 ☐ Yes	2□ No	
ita	artifica ctor,	Be (	25. Was case referred to medical examiner?						eath (Check only	one)			
2	Physician: this certific ral director,	2	1 ☐ Yes 2 💢 No			-	ent 3 DOA		Home 5 ☐ Resi			city)	
u .		on:	27. Manner of Death 1 XNatural 5 ☐ Pend	ing (M	te of Injury onth, Day Year)	28b. Time In <del>j</del> ury	W	uryat ork? ⊒Yes 2∐No	28d. Describe	now injury	occured		
sio	Attending r death. sctor: After oy the fune	icat	3 ☐ Suicide 6 ☐ Could	tigation I not be 280 Pla	ace of Injury - At I	home farm			28f. Location (	Street and	Number or Ru	ıral Route Nuп	nber,
=	# # E	Certification:	4 Homicide deter	mined bu	ifding, etc. (Spec	ify)	street, factory, office		City or To				
	Hospital 24 hours a Funeral (ely filled		29a. Certifier 1 X Certify	ing Physician: To	the best of my kr	nowledge, de	ath occurred at the	time, date and place	ce, and due to the	cause(s)	and manner as	stated.	۵)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	one)	1-5	anner stated.	iation and/or			ouned at the time,				J,
	Vith Com	Σ	29b. Signature and title of certifi				29c. Lice	nse number			signed (Monti		
	: 0/		,	N.			D516	43	]	Febru	ary 21,	2006	
	13		30. Name and address of parso					Fredori	ck Mary	1 and	21702		
	- C+	ate	Hiren N. Shah,		: Thomas	naturo	Ca .	, rrederr	ck, mary	_and	21/02		
-	Regist		MAR 0		Deven.	AX A	resell						

			1 - For State Registrar	State of Maryland		artment of H			ene g. No. 006	06027
*	Physici		1. Decedent's Name (First, Middle, Last)  George J., Fink					2. Date of Death Month	Day Yea	3. Time of Death
	/Medio		4a. Facility Name (If not instrution, give	S HOSD/HA	1	4b. City. Town, or	tocation of Death	, IEBICO.	4c. County of De	7/
ç	- Funeral Director		213-03-7262	M 2⊠F 7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 2.	rear)	Birthplace (State or Foreign Country) Shington D.C.
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Howard		Town or Lo					10d. fnside City Limits 1 ☐ Yes 2X No
	h with the	al Director	10e. Street and Number 3417 Font Hill Dr			10f. Zip Code 21042		10	g. Citizen of What	Country?
920	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heath and Mental Pygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, I' a Medical Examination involved to a builded.	by Funeral		12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 23☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		_
21215-0036	l within 72 ho liene. r than "natur r a Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation a completed) Colfege (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired Ceman	ation furing most of work. )	ing 1	6b. Kind of Busine	
Maryland 2	ild be tiled lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last)  Jacob Fink				18. Mother's Name	Rosen		c offy
Aary	2 shou and N is mai		19a. Informant's Name/Relationship (Ty			ng Address (Street a				
Baltimore, I	Pages 1 and nent of Health int: If item 27 iry or other t		Shirley Wilburn  20a. Method of Disposition  1 (X)Burial 2 Cremation 3 Pa  4 Donation 5 Other (Specify)	emoval from State	netery, crer	Riverside stion (Name of matory or other place Cemetery	e)	Date 2	t City M Oc. Location - City llicott C	or Town, State
Balti	permit. Departm Importa		21. Signature of Euneral Service License		7 22	2. Name and Addres	s of FacilitySte	cling Asl	nton Schw	vab Witzke MD 21228
8	Physician /Medical Examiner		23a. Part1. Enter the disease, or compfishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	e cause on each line.	Do not ent	er the mode of dying  LIMIC  TESTIN	g, such as cardiac (	or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
.O. Box 6	death certif e attending id tor use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. ff yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
rds, P	The law requires that the side has been signed by the bage 2 should be detache		Part II. Other significant conditions cor		ting in the u	nderlying cause give	on in Part I.			to the cause of death?  Probably 4 Donknown
Vital Record		Completed						24a. Was an autopsy perform	ed? _ death	autopsy findings available to completion of cause of ?
Vit;	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: □ inpatient 2□E	R/Outpatier	it 3□ DOA Othe	26. Pface of Death		nce 6 □Other (S	
Division of	ding Atter tune	ation: T	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	1	28b. Time of Injury	28c. Injury Work	at	28d. Describe how		респу
O V i v	or A liter Direction by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)				City or Town,	State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely tilled	Medical	one)	ner: On the basis of examination and manner stated.	ladgs, death on and/or in	vestigation, in my op	oinion, death occurr	ed at the time, da	te and place, and c	lue to the cause(s)
)	T wit	T.	29b. Signature and title of certifier	ws		DOO			d. Date signed (Mo EBRUAR)	
	V		30. Name and a s of person who co	mpleted cause of death (Item ;	23a) (Type,	Print) 50 WIL	CEN S-AU	E #307	- BALTIM	INF MD 21229
1.5	Sta Registr		31. Date filed (Month? Day, Year)  MAR 0 1 2006	32. Registrar's Signatu	le l	and a				

FINIC, GENERAGE

Robert Allen Flowers 06-01404

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental  Certificate of Death	Hygiene
Certificate of Death	Reg. No.

			For State Registrar		State of M	iaryiani					nental Hy	ygie	ne)	NA	060	2 !
							Ce	rtificate (	of Deat	n		Reg.	No.	<u> </u>		
	Physicia /Medic	al		Allen Flo	owers			4 65 7			2. Date of D Month Februa				3. Time of De 11:28	
	Examin	er			e street and number gton Medic		nter	4b. City, Tow	n, or Location					y of Death  Arur		
	F		5. Social Security N				ast birthday)		ear   If Und		8. Date of B	inth				oreir
	Funeral Director		253-71-0 Usual Residence of	182	<b>(</b> □M 2□F	18	Yrs.	Months Da	ys Hours	Min.	8. Date of B (Month, D 10/25	19/19	87		place (State or F ntry) nblee, G	
	/land	1	10a. State	10b. County		10c. City	, Town or Lo	ocation							10d. Inside City	Limit
	Man	tor	MD	Anne Arui	ndel	Pas	adena								1  Yes 2	Хи
	th the	Funeral Director	10e. Street and Nu	mber				10f. Zip Co	ie		-	10g.	Citizen of	What Cou	ntry?	
	ath wi	ai	1309 Wa	iter Oak I	Orive				122				USA			
	e de e	Jue	11. Marital Status		12. Was Deceden Armed Forces	?	5. 13.	Was Decedent If Yes, specify	of Hispanic ( Cuban, Mexic	Origin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	io-		ice - Ameri ack, White,	can Indian, etc.	
920	urs afte	þ	1)☐ Never Marr 3 ☐ Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			1 □ Yes 2 🙀	No Specia	fy:			Speci	₩ Whi	ite	
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heetih and Mental hygiene. Importent: If Item 27 is marked other than "naturel", or itams 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	Completed		15. Decedent's E cify only highest gra	ade completed)		16a. Dece (Give	dent's Usual O	cupation one during material	ost of worl	king	16t	. Kind of E	Business/Ir	ndustry	
77	lene.	E O	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	Stude					Р	uhlic	Scho	ool Syst	Δĭſ
ğ	il Hyg	Bec	17. Father's Name	(First, Middle, Last	)		0000	3,110	18. Mot	ther's Nam	e (First, Middl				JOI DYS	2111
<u>la</u>	uld by Menta vrkad	Total	Larry Flowers Tara L. Bartels													
lan	and Pand Permanent		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,									n, State, Zij	o Code)			
$\mathbf{z}$	and 2			Monticel 1	li/mother		1309	Water_	Dak_Dr.	ive.	Pasader	oa.	MD 2	1122		
ore	P of H		20a. Method of Dis	•	Removal from State	CE	төгөгү, сгө	matory or otner	place)							
Ē	Per tmeni tent: jury		4 Donation	5 Other (Special	y) (Y	Met	ro Cre	ematory		3/1/	2006	В	altim	ore,	MD	
Ba	Depari Depar Impor eny In		21. Signature of Fu	uneral Syrvice Loce	K. 4 1		2	2. Name and A	intain	Sta Rd	llings Pasade	Fu	neral	Home	e, P.A.	
			23a. Part1. Enter t shock, or hea	the disease, or com	plication that use	d the death line.	. Do not en	ter the mode of	dying, such a	as cardiac	or respiratory	arrest.	110-2	.1-124	Approximate Interval Betwe	ən
V.	Physician		Immediate Cause disease or condition	on	: Mil	etipl	eI	uni	05						Onset and Dea	ith
	/Medical Examiner		resulting in death)	(	Due to (or a	s a consequ	ence of):	0								
		ē	Sequentially list contains to in cause. Enter Under	onditions,	b. Due to (or as	s a eurisequ	enes of):									
X	uted d ansit	Examine	Cause (Disease or that initiated events	ininth .												
o o	exec en an rial-tr	Exa	resulting in death)	Last	Due to (or as	s a consequ	ence of):									
928	cate be physicia the bu	dicai		•	d											
P.O. Box 68760,	that the death certificate be executed of by the attending physicien and detached for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 [ 9 Unknown	! months? □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3[	Ectopic pregn Other (specify						ate of delivionth	ery Day Yea	ır
σ.	that deti	۵	Part II. Other signif	ficant conditions	contributing to death	but not resu	Iting in the u	nderlying cause	given in Par	11.	23e. Did	tobac	co use con	ntribute to t	he cause of dea	th?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 24a. Was an autopsy performed?

26. Place of Death | Check only one

1 Yes 2 No

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 D Yes 2 □ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

5 Pending

6 Could not be determined

Hospital: 1 ☐ Inpatient investigation

2 ER/Outpatient 3 DOA 28b. Time of Injury 10:43 PM

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred & jected

C (upant of a unctor

Velucle accident

28t. Location (Street and Number or Rural Route Number,
City or Town, State) w B H cuntous Rd a

Carden ive Pasadeura A

29a. Certifier (Check only one)

27. Manner of Death 1 Natural

2 Accident 3 Suicide

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

O.C.M.E.

29c. License number

29d. Date signed (Month, Day, Year) February 25, 2006

Vi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(H) (1 1 A i A ) (M) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

1

signed by the a d be detached fo

page 2

within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral of

δ

Be Completed

Certification:

Division of Vital Records, P.O.

31. Date filed (Month, Day, Year)

MAR 0 1 2006

32 Registrar's Signature



			1 - For State Registrar	State o	of Marylar		irtment of F tificate of i		and Mer		jiene eg. No.	006	06029
			Decedent's Name (First, Middle	, Last)					2.	Date of Dea Month	th	Vana	3. Time of Death
	hysicia/ Medic/		Mary Anna Fo	ornoff					F	ebruar	у 26	, 2006	5:47 p M
E	Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	of Death		4c. County of Death			
			Dorchester Gene				Cambrid		24 400	0 / 0		rcheste	
	uneral		5. Social Security Number	6. Sex 1 □ M 2√2 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under a	Min.	Date of Birth (Month, Day			place (State or Foreign ntry)
	rector		213-34-1070 Usual Residence of Decedent	A	69					ebruar	у 11	, 1937	Maryland
yland	MOL.		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
Mar	a-f si	ctor	Maryland Dorche	ester	Hur	lock							1 ☐ Yes 2 ☐ No
£	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	en of What Cou	ntry?
ath w	123a	rai	100 Andrews St.				21643				U.S.		
er de	Itams	Funerai	11. Marital Status	Armed Fo	edent Ever in U orces?	l.S. 13.\	Vas Decedent of H f Yes, specify Cuba	ispanic Orig In, Mexican	gin? (Specify n, Puerto Ric	y Yes or No- an, etc.)	14	<ol> <li>Race - Ameri Black, White,</li> </ol>	
d (17.1.5.1.5.1.5.1.5.1.5.1.5.1.5.1.5.1.5.1	I, or	by F	1 ☐ Never Married	ed 1 □ Yes If Yes, Gi Year or D	Ve		☐ Yes 🏖 No	Specify:			S	Specify: W	hite
2 hou	cal E		15. Decedent	's Education		16a. Deced	lent's Usual Occup	ation			16b. Kind	d of Business/Ir	ndustry
hin 7:	man.	ble	(Specify only highes Elementary/Secondary (0-12)	College (		life. I	kind of work done of NOT use retired	during most d)	t of working				
A be with	ar th	Completed	11			Homem	aker					n Home	
be file	even	Be	17. Father's Name (First, Middle,	.ast)						irst, Middle, i		iumame)	
should be	natic	To	John Richter	in (Time Brint)		10h Mailie	- Address (Ctross			Boyer		Town Ctata 7:	- 0- 4-1
d 2 st	7 Is r traur		19a. Informant's Name/Relationsh Linda Barlow- da				g Address <i>(Street :</i> Jackson S						0 (000)
Heal	itam 27 is markad other than "natural", or itams 23a or 28a-1 show other traumatic event, the Modical Examinating as Louisified at		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date			ation - City or T	own, State
Pages 1 and 2 ment of Health a	nt: If i		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		State		ge Mem. I		3/2/20	06 F	lkri	.dge, Ma	ryland
permit. Page Department	Important: If itam 27 Is any injury or othar trau <u>once</u> .		21. Signature of Funeral Service I		/	22	. Name and Addre	ss of Facility	ty				_
<u>a</u> <u>a</u> <u>a</u>	any ir		Mogh	M01234	f	Ga: 72	ry L. Kau 50 Washir	uiman arton	Funer Blvd	al Hom Elkri	e at doe	_MD_210	NC.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	th. Do not ent	er the mode of dyin	g, such as	cardiac or re	spiratory arr	est,		Approximate Interval Between
Phys	sician		Immediate Cause (Final disease or condition	. 5	-n515								Onset and Death
	edical miner		resulting in death)	Due to	(or as a consec	quence of):							t cross
LAG		16	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseq	IVC	eust Fr	ande	in				week.
pet	nsit	Examiner	Cause (Disease or injury	6	(or as a conseq	jubilica dij.							
• өхөсг	n and ial-tra	Еха	that initiated events resulting in death) Last	cDue to	(or as a conseq	juence of):							
cate be executed	physician and the burial-transit	dicai		d									
diffica a	O ci		IE EELAALE.	200									
th cer	attending p	an/l	1F FEMALE: 23b. Was decedent pregnant		tcome of pregnation		Ectopic pregnancy	,			23	3d. Date of deliv	ery Day Year
Physician: The law requires that the death certif	signed by the attendin d be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg	nant at time of d lown	leath 5□	Other (specify)					IVIO I (III	Day
that th	ed by detac		Part II. Other significant condition	ns contributing to c	leath but not res	sulting in the ur	nderlying cause gry	en in Part I.		23e. Did tol	pacco us	e contribute to t	he cause of death?
uires,	sign d be	d by				•				1 □ Y	es 2 🗆	No 3 Prol	bably 4 Unknown
5 %	has been signed 2 should b	Completed								24a. Wasa	n	24b. Were auto	opsy findings available
he la	e has	dmo								autops	ned?	prior to co death?	mpletion of cause of
an:	certificate	a	25. Was case referred to medical					26. Place	of Death (C	1  Yes _3 heck only on	e)	1 🗆 Yes	NO
ysicl	direc	To B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3□ DOA Oth	00				□Other (Specia	(y)
5 g	fter th		27. Manner of Death  1 Natural 5 □ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c. Injun Wor	y at k?	28d	Describe ho	w injury	occurred	
tandil eath.	or: A	cati	2 Accident investig	jation			M 1 🗆	Yes 2□					
or At	Direct in by	Certification:	4 Homicide determine	ned 286. Place	e of Injury - At h ling, etc. (Specif	ome, farm, str fy)	eet, factory, office		281.	City or Town		Number or Run	al Route Number,
To the Hospital or Attanding Physwithin 24 hours after death.	To tha Funaral Director: After this certificate ha completely filled in by the funeral director, page		29a, Certifier 1/1 Certifyin	g Physician: To the	e best of my kno	owledge, death	occurred at the tin	ne, date and	d place, and	due to the co	ausa(s) a	nd manner as s	stated.
e Ho:	a Fur letely	Medicai	(Check only 2 Medical I	Exeminer: On the b	pasis of examination	ation and/or inv	restigation, in my o	pinion, deat	th occurred a	at the time, d	ate and p	lace, and due t	o the cause(s)
To th withir	To th	M	29b. Signature and title of certifier				29c. Licens	e number		2	9d. Date	signed (Month,	Day, Year)
			16 hauchx	LINI a	tuida	, Physi	al DI	11771			2/2	7/06	
1	1		30. Name and address of person								1		
	1		Dr. Vinodrai Me	ehta 300	Byrn S	t., Car	nbridge,	MD 21	.613				
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	1 2006	Byrn Signa	M. A.	ade						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death GILLIS TANNER Month Day Year FEBRUARY 25 ZEO 6 **Physician** MARGE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner OLD COURT NURSING HOME RANDALISTOWN BALTIMORE FUTURECARE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 🖾 F 11.26.1965 216.88.0936 MD Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Itam 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Mexical Examiner must be northed at 1 ☐ Yes 2 ØNo Funeral Director MD BALTIMORE WINDSOR MILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 8339 CIRCLE Α MINDALE USA 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Peges 1 and 2 should be filed within 72 hours after 1 ☐ Yes 202 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Ø No Specify. Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life,\_DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 4 YRS Elementary/Secondary (0-12) TEACHER EDUCATION 1214 GRADE YR\$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) end Mentel JAMES SCOTT BETY GILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Depertment of Health e Important: If Itam 27 Is any Injury or other trau WILLIAMS (MOTHER 2806 WINSOR AVE., BALTO. MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03.04.06 BAUTO, MO 4 ☐ Donetion 5 ☐ Other (Specify) ARBUTUS 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service License angon 5151 BALTO. NATI PIKE BALTO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires thet the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 12 No 1 ☐ Yes 2 € No 1 Tyes 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No Medical Certification: To 28a. Date of Injury (Month, Dey Year) eral Director: After thi filled in by the funeral 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 [] Naturel 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral C 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 37333 FEBRUARY 25 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5400 OLD COURT RD, MD, 21133 A AVI MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**DHMH 16 Rev 6/95** 

altimore, Maryland 21215-0020

Box 68760.

Division of Vital Records.

**Physician** WILTON 7:18 A M GILLIARD 27 /Medical rebruary 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Agnes Hespital Baltimore NIA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 MM 2 □ F 251.22.246 83 Yrs. Director SC 07.06.1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow th and Mental Hygiene. I? Ie marked other then "natural", or Items 23s or 28s-1 ehov traumatic event, the Madical Examiner must be notified at N/a **Baltimore** Yes - 2/2 No MD BALTIMORE Director RANDAUSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 W. KINSEY 21223 AVENUE USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 K Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20% Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: BLACK Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE 12 TH GRADE STATE OF MD NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN E. GILLIARD ဨ JUUA 3 COTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health WIFE) MARTHA GILLIARD 2718 W. KINSEY AVE. BALTIMORE. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 03.08.06 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERMOR Vaughn 5151 BAUTO. NATE PIKE, (21229) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial in Larct Hours /Medical Examiner Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ortic Due to (or as a consequence of) Examine The law requires that the death certificate be executed Bladder Cancer ivision of Vital Records, P.O. Box 68760, Physician/Medical Heart years. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 □Unknown been si 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? icate has t 24a. Was an autopsy performed certificate 1 Yes 2 1 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No ٩ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 Centifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Tens 105, C, d per fn 8853 3-1-06 vt

State of Maryland / Department of Health and Mental Hygiene 0 6

Certificate of Death

2. Date of Death

Month

06031

3. Time of Death

Year

29d. Date signed (Month, Day, Year)

02, 27, 2006

DHMH 17 Rev 1/200

0

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Basel

Dove Alebrahim

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Alebrahim, 900 Caton Ave.

32. Registrar's Signature

ILLIARD, WILTO

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

ORIGINAL

29c. License number

3834

Baltimore, MD 21229

			1- State of		artment of Health rtificate of Death	1	giefle	06032
	Di		Decedent's Name (First, Middle, Last)			2. Date of De Month	nath	3. Time of Death
	Physici: /Medic		Ray Henry Garner			Febru	ary 19 2006	11:39 AM
	Examin	er	4a. Facility Name (If not institution, give street and nu Sinai Hospital of Ba	(timou-e	4b. City, Town, or Location Baltimore	e City	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 1 ₩ 2 □ F	7. Age (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Bir (Month, Da	y, Year) Cour	olace (State or Foreign
	Director		579-56-6822 X W 2 Usual Residence of Decedent	61 Yrs.		Jan 8,	1945 Washi	ngton DC
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	a-f et	Director	MD	Baltimo	re			1√ Yes 2 No
	or 28	Olre	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?
	ath w	ral	2525 W. Belvedere Avenu		21215		USA	
21215-0036	d within 72 hours after death with the Maryland jiene. Ir than "natural", or itama 23a or 28a-1 ehow Ir a Madical Examiner must be nailliad a	by Funeral	11. Marital Status  1 ☑ Never Married  2 ☐ Married  1 ☐ Yes  1 ☐ Yes, Gi  Year or Divorced	orces? 2 🜠 No ve	Was Decedent of Hispanic Off Yes, specify Cuban, Mexica  1 ☐ Yes 2 ☑ No Specify	an, Puerto Rican, etc.)	14. Race - Americ Black, White, Specify: bla	etc.
0-10	2 ho	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/In	dustry
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21	filed with Hygiene. Ithar thai	Con	11 0	disab			none	
pur	e d la	Be	17. Father's Name (First, Middle, Last)			ner's Name (First, Middle,	, Maiden Sumame)	
훒	should be and Mental marked o	2	Leroy Garner  19a. Informant's Name/Relationship (Type, Print)	105 14-16		mie Brown		
Maryland	nd 2 sho eith and 27 ie mu ir traum		Lorraine Ivey/sister		ng Address <i>(Str</i> ee <i>t and Numb</i> Peacock Drive			(Code)
	8 2 8		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date Date	20c. Location - City or To	own, State
Baltimore,	permit. Pages 1 Dep rtment of He Important: If itan any injury or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from '4 ☐ Donation 5 ☒ Other (Specify) in st	ate	matory or other place)			
Bal	Departing any ir		21. Signature of Funcial Service Licensee Konald S. Wade,	rector S	<sup>2. Name and Address of Faci tate Anatomy ] <del>al</del>timore, MD</sup>	Board 655 W. 21201	Baltimore S	Street
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that shock, or heart failure. List/only one cause on a Immediate Cause (Final disease or condition resulting in death)  a	each line.	A	s cardiac or respiratory a farctim t Diseas	(	Approximate Interval Between Onset and Death
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rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to d	eath but not resulting in the u	inderlying cause given in Part		obacco use contribute to the	
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/ita	Phyeiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		0.1	ce of Death (Check only o		
of	this al dir	T <sub>o</sub>		Inpatient 2 ER/Outpatie			dence 6 Other (Specific	y)
nc On (	ng Atter	lon	1 Natural 5 Pending (Mon	of Injury oth, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐		how injury occurred	
Division	or Attending after death. Diractor: After in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm, st ing, etc. (Specify)			Street and Number or Rura wn, State)	I Route Number,
_	To the Hoepital or Attendi within 24 hours after death. To the Funaral Diractor: A completely filled in by the ft	edical Co	29a. Certifier (Check only one)  29 Medical Exeminer: On the band man man	e best of my knowledge, deat basis of examination and/or in oner stated.	th occurred at the time, date a vestigation, in my opinion, de	and place, and due to the lath occurred at the time,	cause(s) and manner as si date and place, and due to	tated. the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier M.D		29c, License number	7 9	29d. Date signed (Month, February 19	
			30. Name and address of person who completed cau Steven L. Jotte M.D. 246				d. 2121	5
	Sta Registr		31. Date filed (Month, Day, Year) 32. F MAR 0 1 2006	Registrar's Signature	And a second			

			110430	State of Maryland / Depart	ment of Health and M	•	-	
		1	1 - For State Registrar		icate of Death		0000	00000
			Decedent's Name (First, Middle, La.		iodio oi bodiii	Reg. I	196	3. Time of Death
	Physici /Medio	al	Denver Wiley	Graybeal		02 21	2006	3;08 A M
<i>&gt;</i>	Examin	er	4a. Facility Name (If not institution, give	1. 101	c. City, Town, or Location of Death		4c. County of Death	
	Funeral		5. Social Security Number V6. S	ex 7. Age (In yrs. last birthday) If	Under 1 Year   If Under 24 Hrs.	8. Date of Birth		10/6
	Funeral Director				onths Days Hours Min.	(Month, Day, Yea		lace (State or Foreign htry) Virginia
	land		10a. State 10b. County	10c. City, Town or Locati	on		1	0d. Inside City Limits
	hours atter deeth with the Maryland turel', or iteme 23a or 28a-f show al Examinar must be notified at	tor	West Virginia Monroe	Peterstown				1 ☐ Yes 2 🕱 No
	ith the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	ntry?
	23a	rail	Route 2 Box476		24963	U.	S. A.	
	ter deeth v iteme 23a	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No 1949	Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	urs att	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No 1949 If Yes, Give 1951 1☐ Year or Dates:	Yes 2█ No Specify:		Specify:	+-
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and	a la b	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid	en Sumame)	
Maryland	N N N N	မ	John E. Graybea  19a. Informant's Name/Relationship (			umate	T 0 7'	2.11
Z	id 2 sho lith and 27 is m traum		Pauline Graybeal		ddress (Street and Number or Rura			
<u> </u>	other tre	Νŝ	20a. Method of Disposition	20b. Place of Disposition	on (Name of	ltimore, M	Location - City or To	
Baltimore,	9 2 2 6		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			/28 006 Mi	dala Dire	Marari and
ij		1	21. Signature of Funeral Service Licer	TIOTTY TITLE	Mem. Gardens 2	J06 MI	date Rive	r, Maryland
ä	Deperment impo		Muchael C. J.	Bri 140	ame and Address of Facility IZdzinski Funera 07 Old Eastern Av	l Home PA Venue Ess	sex, Maryl	and 21221
X	Physician /Medical Examiner pural-transit	Examiner	Sequentially list conditions, fay, leading to inhurching Cause (Final disease or condition resulting in death)  Sequentially list conditions, fay, leading to inhurching cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	hnia			Interval Between Onset and Death
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.O. Box	Q 0 Q	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		opic pregnancy her (specify)		23d. Date of delive Month	ory Day Year
rds, P	w requires thet the been signed by th should be detache		Part II. Other significant conditions of	ontributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?
Division of Vital Records,	elaw hasb je 2 st	Completed				24a. Was an autopsy performed	death?	psy findings available impletion of cause of
/ita	stcian: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
£	die A	၉	1 ☐ Yes R No			me 5 Residence	6 ☐Other (Specify	()
ou o	fer fine	lon:	27. Manner of Death  UNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Injury	Work?	28d. Describe how in	jury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined			28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	ns Hospit. n 24 hours ne Funera	Medical C	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best of my knowledge, death oc niner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, igation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	To the vithing To the comp	ž	29b. Signature and title of certifier	1/1	29c. License number	29d. [	Date signed (Month, I	Day, Year)
	V		2 ha		D0055345	02	-26-2	2006
	311		30. Name and address of person who	completed cause of death (Item 23a) (Type, Prin		mace 112	1 2123	<b>-</b>
	Sta Registr	_	31. Date filed (Month, Day, Year)	32, Registrar's Signature	P -	111016,1119		
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DHMH 17 Rev 1/2001

Graybeal, Denver

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	-	For State	State of Mi		Certificat				.g. No. 0 0 6	06034
	V.	Registrar  1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	th	3. Time of Death
Physicia		JUNE C.		GETNER				Februa	770	006 1600 M
/Medic		a. Facility Name (If not institution, giv			4b. City,	Town, o	r Location of Death	1	4c. County of I	
		UPPER CHESAPE	AKE MEDIC	CAL CEN	1111	BEL r 1 Year	AIR If Under 24 Hrs.	9 Date of Birth		FORD
Funeral		5. Social Security Number 6. S 214261873	Sex 7. Ag 1 ☐ M 2 □ XF	ge (In yrs. last bir.	Yrs. Months		Hours Min.	8. Date of Birth (Month, Day JULY 2	Year) 1931	Birthplace (State or Foreign Country) MARYLAND
Director		Usual Residence of Decedent	, , , , , , , , , , , , , , , , , , ,	/ 1				0021 2	, , , , , ,	
yłano		10a. State 10b. County		10c. City, Tow						10d. Inside City Limits 1 ☐ Yes 24 No
e Mar	ctol	MD HARFOI	RD	WH	IITEFOR					
1215-0036 within 72 hours after death with the Maryland ene. than "natural; or items 23s or 28s-f show the Macifal Exemples must be notified at	Funeral Director	10e. Street and Number 1920 SUSQUEHAI	NNA HAT.T.	BOAD		211	60		l 0g. Citizen of Wha	SA
eath v	erai	11. Marital Status					Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		American Indian,
ter d	Fun	1 Never Married 2 Married	12. Was Decedent Armed Forces: 1 Tes 2X	No.				o Rican, etc.)		White, etc.
036 ours a	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes					WHITE
5-0 72 h	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	. Decedent's Usu (Give kind of we life. DO NOT to	al Occup	oation during most of wor	rking	16b. Kind of Busin	ness/industry
Aithin Man	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	CLERK	120 101110	u)		RETAIL	SALES
d 2 d 2 Hygi	မ C	17. Father's Name (First, Middle, Last	t)				18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
irylan should be and Mental marked c	To Be	ALFRED C	LASING						NEAL	
DCC, Maryla  Tore, Maryla  Ges 1 and 2 should In of Health and Meni  Hillem 27 is marke, or other traumatic		19a. Informant's Name/Relationship								ate, Zip Code)21160
e, M		CHARLENE PERRY	Y/DAUGHT		920 SU		EHANNA	HALL RD	. WHITE 20c. Location - Cit	
Baltimore, Baltimore, Department of Heal Important: If item 2 any injury or other ones.		20a. Method of Disposition 1 → Burial 2 → Cremation 3 [		cemete	ory, crematory or HILL	other pla	ce) 2 /			RIVER, MD
Stimen times		4 □ Donation 5 □ Other (Special Service Lice		повы		nd Addre	1			FUNERAL HOM
Baltimo Baltimo permit. Page Department of important: if any injury or one		21. Signature of Funeral Service God	311500							, MD 21237
Baltimore, N Baltimore, N permit. Pages 1 and Department of Health important: if item 221 any injury or other tr once.		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that cause y one cause on each						rest, HIOFRA (	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or a	s a consequence		3U.	ONTICUI	VC 195 11K	CHOTALIA	30
Examiner		Sequentially list conditions	b							
d /₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequence	of):					
760, c	Examine	that initiated events resulting in death) Last	cDue to (or a	s a consequence	of);					
760, 760, te be ev	calE		d							
687 687 gphys as the	edic		d							
LM # 800+52002  Records, P.O. Box 68760,  The law requires that the death certificate be executed to has been signed by the attending physician and attended for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Petal death	h 3⊟Ectopic (	oregnand	;v		23d. Date of	*
O. B	sicia	in the past 12 months?		at time of death	5 Other (s				Month	Day
P.O. that the de by the detached	Phy	9 Unknown  Part II. Other significant conditions	contributing to death	but not resulting	in the underlying	cause or	ven in Part.I.	23e. Did to	bacco use contribu	ute to the cause of death?
Cords, P wrequires that s been signed is should be detail	Ď	CARR	G CHNON	VIC OF	BSTRUCT	WK	Puliyan			Probably A Unknown
Should Should	Completed	304736				_	ease.	24a. Was	an 24b. We	re autopsy findings available
Rec	dme							autop perfo	rmed? price	or to completion of cause of ath?
Vital Record Iclin: The law requir centricate has been a	Be Co	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only o	100	1165 200
of Vilta Of Vilta Physician: this certific	To B	examiner? 1 ☐ Yes 2 No	Hospital:	ient 2 ER/O	utpatient 3 🗆 🗅	OA Ot	her: 4 🗍 Nursing H	Home 5 ☐ Resid	lence 6 Other	(Specify)
n o n o Ph		27. Manne of Death  1. Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. a <i>y Year)</i>	Time of Injury	28c. Inju		28d. Describe f	now injury occurred	
Vision Vision Attending	cati	2 Accident investigate 3 Suicide 6 Could not	ha -		М		Yes 2 □No	29f Location (6	Street and Number	or Rural Route Number,
Division  Lor Attending alter death alter death in by the func	Certification:	4 ☐ Homicide determine	d 200. Flace of 1	njury - At home, f etc. <i>(Specify)</i>	arm, street, racto	егу, опісе		City or Tox	vn, State)	or Harar House Hamber,
Division of Vital Re Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha		29a. Certifier Certifying F	Physician: To the bes	at of my knowledg	ge, death occurre	d at the t	ime, date and place	e, and due to the urred at the time,	cause(s) and mann	ner as stated. d due to the cause(s)
To the H within 24 To the F complete	Medical	one)	and manner s				ise number			Month, Day, Year)
To with Con		29b. Signature and title ovcertifier	-11	. No		7	2619	1 5	2/25/	2001
		30. Name and address of person who	o completed cause of	death (Item 23a)	(Type, Print)	110	Deliner 6	to Calla	du le	21047
4		30. Name and address of person who			ELAIR 1	611	SUITE	- HILLS	av, Mi	12071
Sta		31. Date filed (Month, Pay, Year)	2006 32. <b>Re</b> gis	strar's Signature	1 .00	Mind				
Regist	rar	0 T	C000	was all	1.00010	-				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of I				t of H	ealth a		ental Hy		006	06035
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle  VECOO  4a. Facility Name (If not institution,  2414 POTTERSF	give street and number		dn	4b. City,	Town, or	Location o	of Death	2. Date of Dea Month FEBRUA	Day RY 2	Year 6, 2006 County of Deat BALTIN	h
	Funeral Director		5. Social Security Number 216-18-3224  Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da)			hplace (State or Foreign buntry) RYLAND
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show Jical Estainst out be notified at	Director	10a. State 10b. County  MD • BALTI  10e. Street and Number	MORE		y, Town or Lo	Ν							10d. Inside City Limits 1
	death with the ms 23a or 3	Funeral Dir	2414 POTTERSE	12. Was Decede	nt Ever in U	.S. 13.1		21244		gin? (Spe			en of What Co USA  4. Race - Ame	
9600	72 hours after on naturel', or Iter	by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ሺ Divorced	If Yes, Give Year or Date	□No		1□Yes 2	∑X No	Specify:	, Puèrto I	cify Yes or No- Rican, etc.)		Black, White	
21215-0036	within liene, r than "	Completed	15. Decedent (Specify only highes  Elementary/Secondary (0-12)  -10-	s Education t grade completed)  College (1-4c	or 5+)		dent's Usua kind of wor DO NOT us NESS (	k done a e retired,	luring most )	of working	ng		d of Business/	Industry  ECORD SHOP
Maryland 2	be filed Ital Hyg Id othe event,	To Be C	17. Father's Name (First, Middle, I AMOS GARDNER								(First, Middle, MANNS			
	s t and 2 should t Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationsh MICHELE GARDN  20a. Method of Disposition			241	L4 PO]	TERS	SFIEL	D RD	Route Numbe WOODL	AWN,		AND 21244
Baltimore,	permit. Pages Department of I Important: If its any injury or o				" GA1	HIBNER:	FORES	T VI	ETERAL s of Facility	NS 3	-7-2006 LLIPS F	OWI:	NGS MIL AL HOME	LLS, MARYLAN
8760,	cate be executed  Wedical  Wedical  Examiner  The burial-transit	lical Examiner	23a. Pan1 Anter the disease, or shock for heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence as a c	uence of):	er the mode	of dying	g, such as	cardiac o				Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate ite has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ŒNo 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta tat time of d	Ideath 3	Ectopic pre					23	3d. Date of deli Month	very Day Year
<u>a</u>	w requires that I been signed by should be deta	by	Part II. Other significant condition  Alzheir		but not res		nderlying ca	, '	,		23e. Did to			the cause of death?
Vital Records,		Completed										sy med? 2☐₩6	prior to death?	topsy findings available completion of cause of
of	Attending Physicien: r death. ector: After this certifica by the funeral director, p	ation; To Be	25. Was case referred to medical examiner? 1   Yes   2   No   27. Manner of Death 1   Natural   5   Pending investig	28a. Date of I (Month,	THE RESERVE THE PARTY OF THE PA	ER/Outpatien 28b. Time of Injury		3c. injury Work	r: 4 □ Nur	rsing Hon 2	Check on one of Residers of the Security of th	ence 6		cify)
Division		Certification;	3 Suicide 6 Could r 4 Homicide determi	ned 286. Place of building,	etc. (Specil	(y)					City or Tow	n, State)		ral Route Number,
	th E th	Medical	one)	Physician: To the be examiner: On the basis and manner	s of examina	wledge, death	vestigation,	in my op	inion, deat	d place, a	d at the time, o	late and p	place, and due	to the cause(s)
,	2 1 1 1 1 1 1 1 1	-	29b. Signature and little of certifier  30. Name and address of person of	who completed dause of	of death (Iter	n 23a) (Type,		License		37			signed (Month	26,2006 21797
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 1 21	Stefana 32. Regi	strar's Signa	250	SK	27+11	n, 6.	te (		w	colbin	em 21797

State of Maryland / Department of Health and Mental Hygierie | | | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 02 **Physician** Hatchett 06 7:20A M Fannie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1305 Prince Georges Gunpowder Court Fort Washington If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Yrs Director 233**–**50–7575 98 10 25 07 West Virginia Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at Yes 2□No Director MD Prince Georges Fort Washington 10e, Street and Number 10f Zip Code 10g. Citizen of What Country? 1301 Gunpowder Court 20744 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

and: If item 27 is marked other than "natural, or items 23s and it if item 27 is marked other than "natural," or other treumetic event, it is Medical Examines must USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Black þ 3 ™ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 yrs. Nursing Assistant Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lillie Williams ၉ George Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya McCollough/Goddaughter 1301 Gunpowder Ct. Ft. Washington, MD. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cem. 3-3-06 Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 Marchall 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Myocardial Infarction Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Arteriosclerosis Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2X No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy med? 2• No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. after death Director: , 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DC12309 02-27-06 4 30. Name and address of person who completed cause of death (item 23a) (Type, Frint) Joseph R. Robinson, M.D. 106 Irving St. N.W. #3600 North Tower Wash. D.C. 20010 31. Date filed (Month, Day, Year) 32. Registrar's Signature market ! State 201800 0 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene | 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 26, **Physician** REGINA ANN HEMELT February 2006 12:20P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pickersgill Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day Year) October 29,1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M AXX Mary Land 215-03-3881 Director Usual Residence of Decedent the Maryland 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner trust be notified at ¹□Yes 2√XX Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue 21204 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes A No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No ğ Specify: White 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Francis Hemelt Sr Marjory Mantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20016 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum QRGs. James T Hemelt Nephew 4000 Massachusetts Avenue NW Apt 1113 Washington DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Most Holy Redeemer Cemetery 3/3/06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 No 1 Yes Hospital or Attending Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 vursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of 29d. Date signed (Month, Dav. Year) 6runy27 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day! 32. Registrar's Signature Year) State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yea February 25,2006 **Physician** 8:30 Margaret B. Hackney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 VA 5. Social Security Number 6. Sex **Funeral** 1□M 2⊠F Days Yrs. Director 5/1/1927 579-28-9503 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Director Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21704 2829 Roderick Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Company Telephone Utility permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked other any long or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace N. Body Ollie Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2206 Carter Mill Way Brookeville, MD 20833 Betsy A. Cleveland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet 2/28/2006 Frederick, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee 106 East Church Street Frederick Md 23a, Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENCEPHA/OPAth Immediate Cause (Final disease or condition resulting in death) NO **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical attending I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ho Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Tlinknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the eause of death? ANCER 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No PANCER 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has ILEAILY DISCALE perform certificate 2 No 1 ☐ Yes 2 ☐ No 1☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 3□ DOA 27. Manner Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 U atural 1 ☐ Yes 2 ☐ No 2 Accident To the Funersi Director: completely filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai 29b. Signature and title of certifier pleted cause of death (Item 3a) (Type, Print) 17 10215 Fernwood Rd 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 2006 Month 436 AM **Physician** February rene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Bayview Medical Center Hopkins 8. Date of Birth If Under 1 Year If Under 24 Hrs. (State or Foreign 6. Sex 7. Age Univrs. last birthday. **Funeral** Hours Days 1 ☐ M 2 ☐ F Yrs. Director Peges 1 and 2 should be filed within 72 hours after death with the Maryland Town or Location 10d. Inside City Limits or Items 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1. Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, jetc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during life. DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) Kind of Bysiness/Industry most of working al Hygiene. (0-12) College (1-4or 5+) of Health and Mental Item 27 is marked o 2 20b. Place of Disposition cemetery crematory 20a. Method of Disposition Department of himportent: If Ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1. Shiel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cardiac arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pulmonoury emboli oilateral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner led by the attending physicien and detached for use as the burial-transit Hospitel or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown cete has been signed, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier allopail Holley MD RES OCO February 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hapkins Baynew medical Center 3 4940 Eastern Avenue Baitimore, MD 21224 Abiquil Holley MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006 MAR 0 1

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	Dhuoisi	an.	Decedent's Name (First, Middle, Last)		2. Date of Deatl		3. Time of Death
	Physici /Medic	al	GEORGE ALLEN JAMES	th Ch. T	reprise	yd, 2004	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Naryland General Hosp	4b. City, Town, or Location of Death  Button ORe  last birthday) If Under 1 Year   If Under 24 Hrs.	city	4c. County of Dea	
1	Funeral Director		5. Social Security Number  6. Sex 1 sd M 2 F  7. Age (In ŷrs.	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9.8 Co	thplace (State or Foreign SC
	D.		Usual Residence of Decedent	ty. Town or Location	01 ~~ 1		10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f ehow r reset by notified at	ō		MMORE			1 Ø Yes 2 □ No
$\sim$ 1	r 28a-	rect	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Co	ountry?
0)	23a o	aiD	2034 FULTON AVENUE	21217		USA	
S	er des	Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
-0036	al', or	by	1  Never Married 2  Married 1	1 ☐ Yes 2 🗷 No Specify:		Specify: BL	ACK
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	ring	16b. Kind of Business	/Industry
0 2	within ene. then '	Completed	Elementary/Secondary (0-12)	LABORER		RAILROAD	
(D) B	12 should be filed wand Mental Hygiel and Mental Hygiel Is marked other traumatic event, In	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, N		
$\mathcal{H}_{\mathcal{L}}$	ould by Menta	ToE	ESMAL VUNHOL	MARY R			
Greor	d 2 sh th and th sm 7 is m traum		19a. Informant's Name/Relationship (Type, Print) VALERIE JAMES (WIFE)	19b. Mailing Address (Street and Number or Rur 3020 W. GARRISON A		City or Town, State, .	
	s 1 an f Heal Item 2 other		20a. Method of Disposition 20b. F	Place of Disposition (Name of	Date 2	20c. Location - City or	Town, State
Baltimore,	Page ment c ant: If ury or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	NG MEMORIAL PARK 428	12006 E	BAUTMORE	, MD
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene important: If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow any injury or other traumatic event. The Medical Examinar manal ba notified at 900.		21. Signature of Funeral Service Licensae	22. Name and Address of Facility VAUGHN C. GREENE FL 5151 BAUD. NATU PIKE	WERAL S	SERVICE MD 21229	
	20g		23a. Part1. Entect the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not enter the mode of dying, such as cardiac			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Disorder			Onset and Death
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	D =	ner	cause. Enter Underlying	quence of):			-
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ord	require	ted	<u> </u>		1 □ Ye	s 2 No 3 P	robably 4 Munknown
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Phyeician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificete has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me			24a. Was ar autopsy perform	ned?   death?	utopsy findings available completion of cause of
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	To the within To the	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Mont	h, Day, Year)
	n		30. Name and address of person who completed cause of death (Iter	m 23a) (Type, Print)	0	1	10
_	")		Taju-deen Ohiokpehar, m.	2 40 Maryland	Giener	al Hosp	ortal
	Sta Registr		31. Date filed (Month, Day, Year) 32. Régistrar's Signa	B Love			
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Lewis Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, 27, perlye g853, 3/27/05 TT State of Maryland / Department of Health and Mental Hygiene () () 06-01319 Certificate of Death 1. Deçedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** February 22 2006 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1315 North Patterson Park Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 120M 2□F (RG-INIA 2-13-80-9087 Usual Residence of Decedent Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Madical Examiner must be notified at 1 Yes 2 □ No MD. ALTIMORE Be Completed by Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 315 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 2 No 2 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SERVICE 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Pages 1 and 2 should be nent of Health and Mental JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 ie eny injury or other trau once. 2731 GREENMOUNT MICHELLE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State PALTIMORE, 21. Signature of Eugeral Service Licenses E. CLIVER ST. 13 24213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a rdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis and meningitis due to streptococcus pneumoniae /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and this certificate has been signed by the attending physicien and ral director, page 2 should be deteched for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2□ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Scene Hospital: Certification: To 1 XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME February 23, 2006 codon M, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEUDORE un MIKE 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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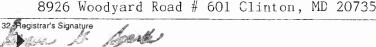
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ii	nit. P partme sortan injur.		21. Signature of Funeral Service Lice		2	2. Name and Addres	s of Facility	i Home		•
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300			23a. Part1. Enter the disease, or conshock, or heart lailure. List only	y one cause on each line.	th. Do not en	er the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
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_	Hospital 24 hours a Funaral ( tely filled		29a. Certifier 1 Certifying F	Physician: To the best of my kn	lowledge, deal	h occurred at the tim	ie, date and place, a	nd due to the cause	(s) and manner as s	tated.
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	į		30. Name and address of person who	o completed cause of death (Ite	m 23a) /Time	Print)	1 1 -	7	SPINA	127,200.
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1	Regist	rar	MAR 0 1 20	106 Mars A	J. A.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death <sup>Day</sup> 2006 Feb 27, 1:37PM M **Physician** Year Oma Adelia Bost Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5800 Blackhawk Drive Prince George's Forest Heights 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 26, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours North Carolina Yrs. Director 242 10 9685 99 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland ment of health and Mentall Hygiene. and the filem 27 le marked other than "paturel", or Items 23a or 28a-f show ury or other traumatic event, the Medical Eventher must be invitibled at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2XXVo Maryland Prince George's Forest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Blackhawk Drive 20745 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√XNo 3 Xividowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Security Agent Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Burns International 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jacob Augustus Bost Dora Jane Nash ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwen Johnson (Daughter) 5800 Blackhawk Drive, Forest Heights, MD 20745 20a. Method of Disposition
14 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. Cedar Hill Cemetery March 6, 2006 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Ligendee Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Massive Pleural Effusion /Medical Due to (or as a consequence of): Examiner Possibly Malignancy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ğ Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000No 1 Yes 2 No 1 🗌 Yes after death.
I Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred Certification: To 1 ☐ Yes 2 🏋 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only onel within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 66 D0013072

Division of Vital Records,

31. Date filed (Month, Day, Year) MAR 0 1 Registrar

Gurbux H. Nachani MD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



		1 - For State Registrar	State of Maryland		artment of H			ieņe 9. No. 006	06044
Phys		Decedent's Name (First, Middle, Last  Kevin		Jones			2. Date of Deat Month	Day Year	
/Me Exan	dical	4a. Facility Name (If not institution, give		JOHED	4b. City, Town, or	Location of Death	Februar	y 25,2006 4c. County of De	
- Laur		Union Memorial Ho	spital			timore		NA	
Funer Directo	_	5. Social Security Number 6. S 212–90–7116 1  Usual Residence of Decedent	ex 7. Age (In yrs. las My 2□F 38	ot birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3–17–	9. B 67	inthplace (State or Foreign Country) Md.
yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
e Mar	Director	Md. NA		Balti	more				†√PYes 2□No
with th	Dire	10e. Street and Number 4400 Chalet Cou	and And O.A.	-	10f. Zip Code 21206		10	og. Citizen of What C	country?
leath na 23	Funeral	11. Marital Status	art Apt. C-4  12. Was Decedent Ever in U.S.	13 V		enanic Origin? (S	pecify Ves or No.	USA 14. Race - Am	origan ladian
Maryland 21215-0036 of 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerti Specify:	Rican, etc.)	Black, Wh	ite, etc.
15-( n 72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired	during most of wor	king	6b. Kind of Busines	s/Industry
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be filed tal Hygical other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, N		
arylai should b nd Ment marked	P		Jones,			Lill		Но	
		19a. Informant's Name/Relationship (7) Patricia Timmons	Sister	523	W. Mosher	Street	Apt. 2,	City or Town, State, Baltimore	
Baltimore, permit. Pages 1 ar Department of Heal Important: If Item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Mt.	te of Dispos netery, crem Zion	ition (Name of latory or other place Cem.	3-3-		oc. Location - City o Lansdowne	
Ball permit Depar Impor		21. Signature Funeral Service Licen	P. Walters	1	Name and Addres March F.H	1. East	1101 E	imore, Md . North A	. 21202 ve.
Prysicial		23a. Pa 1. Inter the disease, or comp shick or heart failure. List only of Immediat. Cause (Final disea e of condition resulting in death)	one cause on each line.		r the mode of dying		or respiratory arre	st,	Approximate Interval Between Onset and Death
/Medica Examine	_	Venes Co.	Due to (or as a consequer	nce of):					
	Je L	Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events	<ul> <li>Биз to (огаз а волаєдизг</li> </ul>	ica of).					
68760, A	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
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Box eath cert attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3 1	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
cords, P w requires that been signed to should be deta	<b>₽</b>	Part II. Other significant conditions co	entributing to death but not resulting	ng in the un	derlying cause give	n in Part I.		:/	o the cause of death?
Division of Vital Records, P.O. or Attending Physician: The law requires that the dafter death.  Director: After this certificate has been signed by the linby the tuneral director, page 2 should be detached	Completed						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
f Vital Roysician: The lis certificate had director, page	Be	25. Was case referred to medical examiner?	Hospital:		100		h Check only one	)	
Of Phys rthis ral dir	<u>ا</u>	1 XYes 2 No 27. Manner of Death		Outpatient		4 Linursing Ho		ce 6 ☐Other (Spe	ocify)
ION ading Ith.	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	es 2 No	28d. Describe hov	vinjury occurred	
Division Attention at our Attention at the dead of the color do in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre			28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	rsician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	s stated. a to the cause(s)
To the within To the comp	Ž	29b. Signature and title of certifier	- 11 -		29c. License	number	296	d. Date signed (Mont	h, Day, Year)
^		30 Name and address of	nelshill in	V)		C.M.E.		February 2	26,2006
3		30. Name and address of person who company to the MADYAMTO (2)	KUROW	111		et Balti	more, Ma	ryland 212	201
S Regis	tate trar	31. Date filed (Month, Day, Year) MAR () 1	32. Registrar's Signature	lo d	00				
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		1 - For State Registrer		aryland / Depa	artment o		, ,	ene •2000 0 6	06045
Physici /Medic		1. Decedent's Name (First, Middle, Las				Jones	2. Date of Death Month February	Day Year	
Examin	er	4a. Facility Name (If not institution, give  The Johns Hopk  5. Social Security Number  6. S	ms Hos	pe (In yrs. last birthday)		more City  ar If Under 24 Hrs		4c. County of Dea	ath rthplace (State or Foreign
Director		212-46-6083 Usual Residence of Decedent	□ M 2[ <b>X</b> F	63 Yrs.	Months Da	ys Hours Min.			Md.
ne Marylar 8a-f show ziified at	ctor	10a. State 10b. County NA NA		10c. City, Town or Lo					10d. Inside City Limits 1 Y Yes 2 □ No
ath with the 23s or 2	Funerai Director	10e. Street and Number 1428 Poplar Grov	e Street		10f. Zip Cod	L216	10	g. Citizen of What C USA	ountry?
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-f show alcal Examination at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces: 1 Yes 2 X If Yes, Give Year or Dates:	No	1 □ Yes 2 🔀 I		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify: B.	
2121 3d within 9jene. er than *	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 8th grade 17. Father's Name (First, Middle, Last)		(Give life.	dent's Usual Oc kind of work do DO NOT use rei sekeepir	ne during most of wo tired) 19	rking	Varies	/Industry
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Baltimore, Mai permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other treun once.		19a. Informant's Name/Relationship (7  Raymond Jones, Jr  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licen	. Son  Removal from State	20b. Place of Dispo cemetery, cref Mt. Zic	B Poplar sition (Name of matory or other) on Cem.  Name and Ad	Grove St	Date 2 -06 Baltime		21217 Town, State , Md. 21202
8760, sate be executed Wedical American and the burial-transit the burial-transit and the b	icai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of the classes or condition resulting in death)  Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence of):	y astri		ocarcimo		Approximate Interval Batween Onset and Death 2 4 hours
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gne gre	by	Part II. Other significant conditions co	ntributing to death b	out not resulting in the ur	nderlying cause	given in Part I.			o the cause of death?
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on of ding Phy h. After this funeral d	ition: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Maner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time of	28c. in	Other: 4 Nursing H	ome 5 Residen 28d. Describe how	ce 6 □Other (Spe	city)
DIVISION al or Attending s after death. In Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	eet, factory, offic	CB	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
he Hospi in 24 hou he Funer pletely fill	edicai	one) 2 Medical Exam	ner: On the basis of and manner sta	of my knowledge, death f examination and/or inv ated.	occurred at the estigation, in m	time, date and place y opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
vith To	Σ		misul to			- 000		I. Date signed (Mont	
3		30. Name and address of person who c	ompleted cause of d		Print)	North Wolfe.	Street Ball	more Mn	yland)
Stat Registra		31. Date filed (Month, Day, Year)	32. Fégistra	ar's Signature	and s				-100 /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Year 6 15 AM FLOUGHY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimore Hospital Baltmore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 218-46-346 Johnson Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits treumatic event, the Madical Examinar must be notified at MD Director 1 Mes 2 No timove GARACTE D. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA Huenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married natural, or Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retifed) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 is marked other than condary (0-12) College (1-4or 5+) Hygiene. Maiden Sumame Pages 1 and 2 should be nent of Health and Mental 19b. Mailing Address (Street and Num. Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s Department of Health ar important: if Item 27 is any injury or other treu once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State re f Fun a Servici 21. Signal Licer 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying shock, or hear failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Adenocarcinoma of 2 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) physicien and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 monus?

1 Yes 2 No 23d. Date of delivery etten for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. Callure 1 ☐ Yes 2 ☐ No 3 Probably 4 Waknown 24b. Were autopsy findings available prior to completion at cause of death?
1 ☐ Yes 2 ☑ No 24a Was an cete hes page 2 s autopsy 1□ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Medical Certlflcation: To Be 26. Place of Death | Check only one Hospital Other: Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner at eath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Ulatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deal To the Funerel Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Bultimore hospita 31. Date filed (Month, Day, Year)

te and address of person who completed

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AMI ATTALI, D.O.

ruse of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of Mary			of Health and of Death		2000	06047
	<i>A</i> .	M	Decedent's Name (First, Middle, La	ist)		imouto	0, 500.,	2. Date of Death	NoUUU	3. Time of Death
	Physic /Medi		DOUGLAS EDWARD					Month OA	35 2000	e 7:50 AM
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	Director		213-78-8839 Usual Residence of Decedent	1 M 2 □ F	58 Yrs.	WOTHITS	ays Hours Will	Mar 15,	1947 Ma	ryland
	laryland •how		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	within 72 hours after death with the Maryland ene. Than "natural", or Itame 23e or 28e-f ehow Ita Marillar must be notified at	Director	Maryland Baltimo	re County	Timo					1 ☐ Yes 2 ☐ No
	with the		10e. Street and Number	D 1		10f. Zip Co		10g	. Citizen of What Co	ountry?
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99	s after or its	by Fu	1 XNever Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give X		Yes, specify		rto Rican, etc.)	Black, White	
(A.S. 5-0036	2 hour	q pe	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		ent's Usual O		16	b. Kind of Business/	Mite
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quffinm, more, Marylan	s 1 and 2 should f Health and Men flem 27 is marke other treumatic	ļ-	19a. Informant's Name/Relationship (		19b. Mailin	g Address (St	Hele	Ural Route Number, C	Jeste City or Town, State, Z	
-	C = 04 -			ouse Counsel	or) Gall 2520	agher Pot S	Center Pring Road	Apt 1B	Timenium,	MD 21093
Tut non	@ ° = '>	1	20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crem	atory or other	place)	140000		Touri, State
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ã	Depermine timbo		Martin D. Lav	ison	M	itchel	l-Wiedefel	d Funeral	Home, Inc	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ente	r the mode of	dying, such as cardia	c or respiratory arrest;	maryland .	interval between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a aspirat		monid	د			Onset and Death
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Вох	Attending Physicien: The law requires that the death certific ir death. •ctor: After this certificete has been signed by the attending p by the funeral director. page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death 3 1	Ectopic pregn			23d. Date of deliver Month	very Day Year
o.	that the de ed by the a detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time 9□ Unknown	of death 5	Other (specif)	y)			Day I bai
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Į.	nysicia nis cert direct	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Outpatient	3□ DOA	0#	ath <i>(Check only o</i> ne) Home 5 ☐ Residence	e 6 □Other (Spec	ify)
0 0	ing Pt		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury		njury at Work?	28d. Describe how i		
isio	of or Attendiate after death.  Director: A in by the fu	ficati	2 Accident investigation 3 Suicide 6 Could not be		At home farm etro		1 ☐ Yes 2 ☐ No	28f. Location (Stree	t and Alumbas as Du	- Courte Musel
D.	2 ± ± €	Certification:	4  Homicide determined	building, etc. (St	pecify)	et, ractory, on	ic <del>g</del>	City or Town, S.	tate)	ar Houle Number,
	To the Hospitel or Attending Physicien: The law requires tha within 24 hours after death.  To the Funaral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	edical (	29a. Certifier (Check only one)	ysician: To the best of my niner: On the basis of exa- and manner stated.	/ knowledge, death mination and/or inve	occurred at the	e time, date and place ny opinion, death occi	a, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
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			mil	(rend)		1	121841	5	2/25/20	Cle
	y		30. Name and address of person who	completed pause of death	(Item 23a) (Type, P	rint) Klin &	mare Doi	s ve ,BAHHIN	nove Mil	21237
10	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature		J. J. C.	, willing		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2200 P M February 25 2006 Charles James Kavalesky /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltinore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. April 20,1934 Maryland

10d. Insic Saint Agnes
5. Social Security Number Saint Hospital 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ½** M 2□ F 213-30-6274 Yrs 71 Director Usual Residence of Decedent 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Exeminer must be notified at MD 1 ☐ Yes 2 € No Completed by Funeral Director Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 Ingleside Avenue 21207 USA or items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes Z∑No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 St Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Stone Mason land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental F ftem 27 Is marked ot Frank J. Kavalesky Dorothy Dahlen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. J. Kavalesky -Brother 1302 Ingleside Avenue; Woodlawn, MD 21207 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Lake View Mem. Park 3-2-2006 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Maryland Funeral Home of Catonsville, Inc. 1630 Edmondson Ave.; Catonsville, MD 21228 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final-**Physician** End stage Li
Due to (or as a consequence of): Liver disease or condition resulting in death) disease years /Medical Examiner Alcohol years use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Circhesis Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hepato-renal syndrome certificate has 2 No 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Makammeo MD P17601 February 25, 2006

State Registrar Nareesa

31. Date filed (Kenth, Day,

DHMH 17 Rev 1/2001

Coasta

Baltimore MD 21229

900 S Caton Avenue

32. Registrar's Signature

180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammed

1 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Eleanor 2006 8:50A ebrhan 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel North Arundel Hospital Glen Burnie Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F 87 Yrs Ĩ918 Washington DC Director 216 09 0746 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b County other then "naturel", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Annapolis Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21403 United States 1225 Gemini Drive Apt B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Who If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No 3.☐Widowed 4 ☐ Divorced Specify: Specify: Completed by White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Housekeeping 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked of (Unknown) Marv John Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1225 Gemini Drive Apt B, Annapolis, MD 21403 Robert King (grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. 4 ☐Donation 5 ☐ Other (Specify) Cedar Hill Cemetery March 1, 2006 Suitland, Maryland 21. Signature of Funeral Seprice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d N's Alexandria Ferry Road, Clinton, MD 100153 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final my o cardral **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or consequence of) Examiner been signed by the ettending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 20 this certificate 1 Yes Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 Tes 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) Manner of Death
Natural
Accident 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 5 Pending 1 Tes 2 No death. investigation Director: / 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide ŏ To the Hospitel within 24 hours e To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad 32. Registrar's 31. Date filed (Month, Day, State 2006 MAR 0 A Second Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Tebruary 26, acol 8:30 14 10. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) N/A 2 If Under 1 Year If Under 24 Hrs. Johns Hopkins B. Date of Bilth DEC. 27, 1933 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 X F Months Hours MD 72 213-32-1440 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 is marked other than "naturel", or items 23s or 28s-1 show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 🕅 No Director BALTIMORE BALTIMORE the 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21208 1317 ST. ALBANS ROAD Funerai 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify. Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental **BLUMBERG** COHEN ANNE BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1317 ST. ALBANS ROAD - BALTIMORE, MD 21208 Health Item 27 LEO KAHAN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
important: If Itel
any injury or ott 1 Durial 2 Cremation 3 Removal from State REISTERSTOWN, MD BALTIMORE HEBREW CEM | 02/28/2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Septice Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart sailure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Ù 0 **Physician** 6 year lom disease or condition resulting in death) /Medical Due to (or as a donsequence of): Examiner dweeks theumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien end for use as the burial-transit Due to (or as a consequence of) Box 68760, certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death P.0. certificete has been signed by the a rector, page 2 should be detached. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No : After this certifice funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ No 1 1 Impatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital or 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and hanner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fund completely fi (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number te bruary D61660 2006 W.D

State Registrar DHMH 17 Rev 1/2001

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Wolfe

Street

Baltimore

Maryland

21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North

32. Registrar's Signature

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31. Date filed (Month, Day, Yéar,

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year NICOLE JANIYAH LANGLEY 10.45 PM 02 2006 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death OF MARYLAND UNIVERSITY BALTIMORE MD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🛱 F Hours 3 Director Yrs. Feb 11, none 2006 Maryland Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d, Inside City Limits or 28a-f ehow Examiner must be notified at Director 1√ Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 N. Carey Street 21223 itema 23a USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced black. "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I've Madical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk is marked o 2 Demetrice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i University of Maryland Hospital 22 S. Greene Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H important: if its eny injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒Other (Specify) in state 21. Signature of Funeral)Service Licensee Royald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street rector ensey 21201 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HOLOPROSENCEPHALY /Medical Due to (or as a consequence of): Examiner FACIAL DYSMORPHISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical nding puse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy or Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has I autopsy performed: 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 TSuicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P18664 Davem 2/11/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, UMMS, Baltimore, MD 2126 Madhavi , 225 areene 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State 2006 0 Registrar

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<u> </u>	should and Men s marke umatic	ပ္	19a. Informant's Name/Relationship (	Tuna Print)		10h Mail	ina Address	(Street			Barney  I Route Number	er City or	Town S	tate Zin	Codel	
Maryland	d 2 sl th an 17 Is r traur		Ashley Barney/ Mothe										, 0 111, 0	iaro, zip	0000)	
	1 and Health tem 27 other tr		20a. Method of Disposition	r	20b. f	Place of Disp cemetery, cre					ore, MU		ation - C	ity or To	wn, State	
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Inportent: If item 27 is marked other than "naturel; or Items 23a or 28e-1 show any injury or other traumatic event. Ite Manical Examiner challed all once.	1	21. Signature of Funeral Service Licer				2. Name ar		1					,		
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Box	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome 1 ☐ Live birth	of pregna		□Ectopic p	regnancy	,			2	3d. Date Mont		ry Day	Year
O. E	he at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of o	death 5	Other (s	pecify)					WONE		Day	i cui
<u>o</u> .	that the de ned by the a detached t		Part II. Other significant conditions	contributing to death h	out not res	sulting in the	underlying (	ausa div	en in Part I		23e. Did t	obacco u	se contrib	oute to th	e cause (	of death?
ds,	90	d by	Tarrit outer signment contained	John Dalling to Coult							10	Yes 2	ŮNo 3	B 🔲 Prob	ably 4	□Unknown
Ö	2 0 0	ete			_						24a. Was	an	24b. W	ere autor	sv findin	gs available
Vital Records,	has has	Completed									auto	psy ormed?	pri	ior to cor eath?	npletion o	f cause of
ja	icien: Th certificate rector, pag	e Co	25. Was case referred to medical						26 Place	of Death	1 Tes	2 No	11.	Yes	2   No	
Ξ	Physicien: this certific ral director,	To B	examiner?	Hospital: 1 Mnpati	ent 2	ER/Outpatie	ent_3 D	OA Oth	or		me 5□Resi		Other	(Specify	·)	
l of			27. Manner of Death	28a. Date of Inju	ıry	28b. Time Injury	_	28c. Injur Wor	y at k?		28d. Describe	how intury	occurre	d	,	
ior	를 근 중 글	atio	1 Natural 5 Pending 2 Accident investigatio	n	, ,	()	М		Yes 2□	No						
Division	for Attendate death Director:	ertification;	3 Suicide 6 Could not be determined		jury - At h tc. <i>(Speci</i>	ome, farm, s fy)	treet, factor	y, office			28f. Location ( City or To			r or Rura	Route N	lumber,
Ω	spitel or At ours after o ieral Direc filled in by	O	W/	1												
	Hospitel 24 hours a Funeral I	edical		nysician: To the best miner: On the basis of and manner st	of examina											e(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	and marrier of			29	c. Licens	e number			29d. Date	e signed	(Month,	Day, Yea	")
	- 51/0		> Set un					Di	64003			6	3	25	200	6
1	2 0		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type	, Print)					, .				
,	2		5 INA	1. Mennie		4W94	22	5. 6.	1 EENE	SME	er Baci	MANE	.0	13 2	21201	
	Sta Regist		31. Date ti <del>led (M</del> qnth, Day, Year) WAR 0 1 20	32 Regist	rar's Sign	ature	SEASE!									

				epartment of Health and M Certificate of Death		iene) 06	06053
			Decedent's Name (First, Middle, Last)		2. Date of Death	h Day Year	3. Time of Death
	Physici /Medio		JUANITA LAMBERT		_	27 1006	4:58 PM
	Examir Funeral		4a. Facility Name (If not institution, give street and number)  9534 Angelina Circle  5. Social Security Number 5. Sex 7. Age (In yrs. last birth	4b. City, Town, or Location of Death    Column   1   1   1   1   1   1   1   1   1	8. Date of Birth	4c. County of Deat  Bat  9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent  10a, State		June 12	3,1 <b>9</b> 27/Vi	10d. Inside City Limits
	he Maryla 28a-f shov ciilled at	Director	Maryland Howard Col	Umbia 10. Zip Code	10	0g. Citizen of What Co	1 Yes 2 □ No
	hours after death with the Maryland tural', or Items 23a or 28a-f show at Examinational be notified at	Funerai Dir	10e. Street and Number  9534 Angelina Circle  11. Marital Status  12. Was Decedent Ever in U.S.	2 10 4 5  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F		USA 14. Race - Ame	rican Indian,
920	urs after d al', or Iten	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto for 1 ☐ Yes 2 🏋 No Specify:	Rican, etc.)	Specify: B	e, etc.
21215-0036	n 72	Completed	(Specify only highest grade completed) (	Decedent's Usual Occupation Give kind of work done during most of workir life. DO NOT use retired)		16b. Kind of Business/	industry
	filed Hygi sther	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, A	Va. Fubil Maiden Sumame)	c Schools
yla	D 9 2 0	ို	George Williams Sr.	Mailing Address (Street and Number or Rura	e VV	City of Town State	in Codel 2 N 77 II 4
Baltimore, Maryland	ges 1 and 2 should of Health and Mit of Health and Mit if item 27 is marl or other traumati		Mr. Victor Lambert 20b, Place of Disposition 20b, Place of Disposition	H2 Survey Circ Disposition (Name of crematory or other place)	le Dr.	Fort Wash	ington 20744 Ington Va : Town, State
ij	Pa ant ury		'4 □Donation 5 □Other (Specify)	u d cemere d' 1	2006	Nortalk	Va.
Bal	permit. Pag Department Important; any injury o		21. Signature of Funeral Service Licensee	Name and Address Cility Joseph L. Kuss 2222 W. North Ave	Funer. Bult	al Home,	P, A,
Į	Pnysician	8 %	23a. Part / Enter the disellise, or complications that caused the death. Do no shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. FNEVMOR/A	or enter the mode of dying, such as cardiac o	r respiratory arre	<b>351</b> ,	Approximate Interval Between Onset and Death  Week
	/Medical Examiner		resulting in death)  Due to (or as a consequence of				
		e e	Sequentially list conditions, if any, leading to immediate b.    MULTIPLE  Due to (or as a consequence of				YEARS
	rate be executed only sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of	f):			
8760,	icate be e physician s the buris	icai	d			ſ	
O. Box 6	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
Δ.	quires that the signed by all be detacted	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	pacco use contribute to es 2 □Ho 3 □ Pr	the cause of death?
Vital Records,	The ate h page	Completed			24a. Was autops perform	24b. Were au prior to death?	itopsy findings available completion of cause of 2 No
/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death			
of	Phys this aldiu	-T	1 ☐ Yes 2 ☐ Mospital: 1 ☐ Inpatient 2 ☐ EP/Outs 27. Manner of Death 28a. Date of Injury 28b. Ti			nce 6 □Other (Spe ow injury occurred	cify)
O	ding h. After fune	tion		me of 28c. Injury at 2 jury Work?  M 1 □ Yes 2 □ No			
Division	₽ # # E	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (St. City or Town	reet and Number or Re n, State)	ural Route Number,
_	Hospita 4 hours Funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Madical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, a for investigation, in my opinion, death occurre	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont	-
	1		1 Am	D51860		FEB 28,	2006
_	10		30. Name and address of person who completed cause of death (Item 23a) (T  TONATHAN 17514 Mg	DS1860 Type, Print) 10760 CHANTEN DA.	IVE #7	so Coum	SIA, AN ZIOYY
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 0 1 2006  A 1 2006	back			

			For State Registrar	ate of Maryland / (	•	ent of Health a ate of Death		ental Hygier Reg.4	211116	06054;
	Н		Decedent's Name (First, Middle, Last)					2. Date of Death Month	)av Year	3. Time of Death
	Physici: /Medic		Robert Willis Moyer				F	EBRUARY	24, 200	6 02:50FM
	Examin		4a. Facility Name (If not institution, give stree Saint Joseph Me			ty, Town, or Location o	of Death QWS 0		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1以 M	7. Age (In yrs. last bit	Yrs. If Un Mont	der 1 Year If Under is Days Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Yea 05/09/193	ar) C	nthplace (State or Foreign country)
	p ,		Usual Residence of Decedent  10a, State 10b, County	10c. City, Tow	m or Location					10d. Inside City Limits
	shov	2								1 ☐ Yes 2 💆 No
	28e-f	Director	MD Baltimore	Phoe		Zip Code		100	Citizen of What C	ountry?
	with sa or		3526 Sweetair Road			21131			J.S.A.	
	death ms 2;	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. Was De	cedent of Hispanic Ori	igin? (Spe	cify Yes or No-	14. Race - Am	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Integrate: If item 27 is marked other then "neturel", or items 23a or 28a-1 show any injury or other traumatic event, I'te Medical Examiner must be notified at once.	by Fur	1 Never Married 2 Married 1	\rmed Forces? ☐Yes 2 <b>∑</b> No fYes, Give 'ear or Dates:	1	pecify Cuban, Mexicar 2X No Specify:		rican, etc.)	Black, Whi	nite
8	2 hou	led	15. Decedent's Education	n 16a	. Decedent's U	sual Occupation		16b.	Kind of Business	
215	Pin 7:	Completed	(Specify only highest grade cor	npleted) College (1-4or 5+)	life. DO NO	work done during mos use retired)	it of workin	ig		
2	ar th	Con	11		Blast			Exp	olosive I	Engineer
nd	ba file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Maid	len Sumame)	
Maryland 21215-0036	d Men narke	ဥ	Harold W. Moyer	Defeat) 400	. A4-10- A-14		lma W			Tie Contain
a N	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship (Type, I		_	ess (Street and Number		i i i i i i i i i i i i i i i i i i i		
Ġ,	1 and Healt tam 2		Karen J. Preston ( 20a. Method of Disposition	20b. Place o	f Disposition (	ley Court			Location - City o	
Baltimore,	ages ant of t: If it		1 ☐ Burial 2 【XCremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	val from State	ry, crematory`	ory, Inc. 0	12/27	/2006 Pa	ltimoro	Maruland
Ħ	nit. Partme ortan injur		21. Signature of Funeral Service Licensee	Metro						al Home, P.A.
ä	per timp dany		Mother Yasselv	7(4)						land 21087
	*		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ons that caused the death. Do	not enter the r	node of dying, such as	cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	PNEUMONIA						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence						
п	Examiner	_	Sequentially list conditions.	CONGESTIVE		FAILURE				
/	ad Isit	ulne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
V.	al-trar	Examiner	that initiated events c resulting in death) Last	CLOSTRIDIUM Due to (or as a consequence	D [ = = 1 of):	CILLE CO	LITI	<u> </u>		-
8760,	cate be executed physician and the burial-transit	dical								
9	rtificate ng physi as the f	a	IF FEMALE:							
Вох	leath certific attending p	an/l	23h Was decodent pregnant 230. I	f yes, outcome of pregnancy I □Live birth 2 □ Fetal death	n 3⊡Ectopi	pregnancy			23d. Date of de Month	elivery Day Year
0	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/M	1 \( \text{Vac} 2 \( \text{No} \)	4□Pregnant at time of death 9□Unknown	5 🗌 Other	(specify)			i i i i i i i i i i i i i i i i i i i	Suy Tour
_	that the d ad by the detached	Ph	Part II. Other significant conditions contribu	uting to death but not resulting i	in the underlyir	g cause given in Part I	 I.	23e. Did tobacc	o use contribute t	to the cause of death?
ds,	uires tha signad Id ba dei	d by			,			1 🗆 Yes	2 No 3 P	robably 4 Unknown
COL	w requir been si should	Completed						24a. Was an	24b. Were a	utopsy findings available
Re	he lav e has age 2	ошо						autopsy performed	prior to death?	completion of cause of
Division of Vital Records,	ician: Th certificate rector, pag	Be C	25. Was case referred to medical			26. Place	e of Death	(Check only one)	10 10	s <b>A</b> No
<u> </u>	Physician: r this certificanal director,	To B	examiner? 1 Yes 2 No	ital: 1 Inpatient 2 ER/O	utpatient 3	DOA Other: 4 No	ursing Hon	ne 5 Residence	6 □Other (Spe	ecify)
0 _	ding Pt h. After th funeral		27. Manner of Death 2 1 Natural 5 Pending		Time of Injury	28c. Injury at Work?	2	8d. Describe how in	njury occurred	
Sio	tendii eath. ior: A the fu	catl	2 Accident Investigation		M	1 Yes 2				
Σ	l or Attene after deatl Director:	Certification;	4 Homicide determined	Be. Place of Injury - At home, fa building, etc. (Specify)	arm, street, fac	tory, office	2	City or Town, St		Rural Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate h completely lilled in by the funeral director, page		29a. Certifier 1 Certifying Physicie	n: To the best of my knowledg	e, death occur	ed at the time, date an	nd place a	nd due to the cause	(s) and manner a	as stated.
	e Hos 24 ho e Fun etely	Medical		On the basis of examination ar and manner stated.						
	To th within To th compl	₹	29b. Signature and title of certifier	n -11 = n		29c. License number		29d.	Date signed (Mor	nth, Day, Year
1			De Francis	mellan	0.0	D41410		1-6	menon.	1 24 /2016
	,		30. Name and address of person who comple	eted cause of death (Item 23a)	(Type, Print)					
	0		JOGINDER F MEHTA	1 July D 760:	1 OSLE	R DRIVE	TOW	SON, MAR	YLAND E	1204
	Sta Registi		MAR 0 1 2006	32. Hegistrar's Signature	law.			*		
	negisti	aı	A T COOD	MENTERS AT ME	SAME					

			1 - For State Registrar	State of Ma	ryland / i	-	rtment o				giene ()	06	06055
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of De		Aser Aser	3. Time of Death
0	/Medic Examir	cal	Julia T.C. Melefsky 4a. Facility Name (If not institution, give s GREATER BALTIMORI	treet and number)	CENTER		4b. City, Tow		n of Death	Februa	4c. Count	2006 y of Death IMORE	08:15 ам
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		(In yrs. last bi		If Under 1 Ye		er 24 Hrs. Min.	8. Date of Bir (Month, Da March 4	th y, Year)	9. Birthp	place (State or Foreign arctoah, PA
2	death with the Maryland ms 23a or 28a-f show mat be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore		10c. City, Tow Long Gr		eation					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
1	with the	Direc	10e. Street and Number 12300 Woodcrest Lane				10f. Zip Coo 21092				10g. Citizen of	What Cour	
16	oms 23	Funeral Director		2. Was Decedent E Armed Forces?	ver in U.S.	13. W		of Hispanic	Origin? (Sp	ecify Yes or No		ce - Americ	
9896	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Modical Examination in at he notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ XN If Yes, Give Year or Dates:		1	□Yes 2√	No Spec			Speci	<sup>ty:</sup> Whit	´e
25-5-15-15-15-15-15-15-15-15-15-15-15-15-	vithin 72 h ne. hen "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5-	+)	(Give k life. D	ent's Usual Ockind of work do OO NOT use re	one during m stired)	ost of work	ting	16b. Kind of E		·
₹200	illed w Hygien other th	Be Co	12 yrs.  17. Father's Name (First, Middle, Last)	N/A	Mec	tical	Assista	_	ther's Nam	e (First, Middle	John C I Maiden Suma		D
Maryland	should be nd Mental s marked o	ToB	Walter Zarcufsky						a Mac				
Mar	and 2 shealth and n 27 is m		19a. Informant's Name/Relationship (Typ.  Julianne M Bowers	e, Print)	191					a <i>l Route Numb</i> g Green			Code)
Jore,	ges 1 a t of Hei if item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemete	of Dispos ery, crem	sition (Name o atory or other	f place)		Date	20c. Location	- City or To	
MEL	nit. Parantmen ortant: injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	θ ,	Parkwo		emetery Assahn F		t		Baltimor	e,Mary	land
_ %	permit. Departr Importe eny inji		Mosthor pessol	in Chan	acki.	74	401 Bela	ir Road	Balti	nore, Mar		236	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	e.  ME  consequence  consequence	GAC ile ile			as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
x 68760,	ate be nysicie he bur	Physician/Medical E	IF FEMALE:									_	
P.O. Box	The law requires that the death certific; site has been signed by the atlending ph page 2 should be detached for use as t	ysician/	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	2 Fetal death		Ectopic pregna Other (specify					ate of delive onth	ery Day Year
	w requires that the de been signed by the a should be detached t	۵	Part II. Other significant conditions con	nbuting to death bu	t not resulting	in the un	derlying cause	e given in Pa	rt I.		obacco use cor Yes 2. No		ne cause of death?
Reco	sician; The law re certilicete has be lirector, page 2 sho	Completed	METAPOL		rosi.c					24a Was auto perio 1 \( \text{Yes} \)	rmed/	death?	psy findings available mpletion of cause of 2 No
Vita	Physician: r this certition ral director.	Be	25. Was case referred to medical examiner?				a 🗆	Othor		th (Check only o			
Division of Vital Records,	ng Phy Iter this	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	nt 2 □ ER/O y Yea <i>r)</i> 28b.	Time of Injury	28c.	Injury at Work? 1 Yes 2		ome 5 Resi 28d. Describe	dence 6 ∐Ot how injury occu		<i>y)</i>
Divis	D the o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, f . (Specify)	arm, stre	eet, factory, off	fice		28f. Location ( City or To		ber or Rura	Il Route Number,
	he Hospital n 24 hours a he Funeral I	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of er: On the basis of and manner stat	examination at	ge, death nd/or inv	occurred at the estigation, in r	ne time, date my opinion, d	and place, feath occur	and due to the red at the time,	cause(s) and m date and place	nanner as s , and due to	tated. o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	8-0111	rock	MI	0 0	cense number	1748	2	29d. Date signi 2-27	1-0C	
	8		30. Name and address of person who	mpleted caus of de	eath (Item 23a)	Type, F	Print)	dons	+ 1	11505	T7111	VOA	21204
I	St. Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Som	Par LON		/ C	0 (2/8	1000	4/	

				<b>Type or Print in BI</b> State of Maryland						00000
			1- Samend Items# 10	e & 19b per FH	Gass	tificate of l	Death	Reg	2.006	06036
			1. Decedent's Name (First, Middle, Las	)				Date of Death     Month		3. Time of Death
	Physici /Medio		CLArence.	E. Miller	SR			Feb 2:	Day Year 2, 2006	740 PM
de la	Examir		4a. Facility Name (If not institution, give	, .		4b. City, Town, or	r Location of Death		4c. County of Dea	
			STELLA Maris	Hospice			ONIUA		BALT	·
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign puntry)
	Director		215-05-7347 Usual Residence of Decedent	//	113.			AUG 24	1908	FID.
	/land		10a. State 10b. County	10c. City,	Town or Loc	ation	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			10d. tnside City Limits
	Man	tor	MD NA		/	BALTIMO	o re			1 ☐Yes 2 ☐ No
	h the	lrec	10e. Street and Number 3601 Gr	eenway Apt. 20	8	10f. Zip Code		100	. Citizen of What Co	ountry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, "he Medical Examiner must be notified at ance.	Funeral Director	4366 Archolm	s AVE			<del>2+2-6</del> 212	18	U.S.A	
	lems lems	nei	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto F	offy Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, e. etc.
36	s afte	by Fu	1 Never Married 2 Married   Married   Married	1 Yes, Give	. 1	☐Yes 2☐No	-			hite
215-0036	hour tural	q pe	15. Decedent's Edi	Year or Dates: NAVU		ant's Houst Occurs	ation	1.6		• -
15	in 72	Completed	(Specify only highest grad	le completed)	(Give k	ent's Usuat Occupa and of work done of ONOT use retired	during most of working	9	b. Kind of Business	rindustry
212	filed within Hygiene. ther than "ont, the Med	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		MANAGER	•		Western	Electric
	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)	75.77	<u> </u>		18. Mother's Name	(First, Middle, Ma	iden Sumame)	
a	Mental Merked o	To B	Joseph Miller	۲.			Christin	u BAR	thol	
Maryland	2 should and Men Is marke sumatic	Ī3	19a. Informant's Name/Relationship (T		19b. Mailing	Address (Street)	and Number of Qural	Route Number, C	City or Town, State, .	Zip Code)
	and 2 salth a n 27 I		Clarence C. M.	Her, JR	4366	Archola.	5 AVE B	alt. M	8-13-6 2	21221
ore	of He		20a. Method of Disposition  1☐ Burial 2 ☐ Cremation 3 ☐ I		ce of Dispos netery, crem	ition (Name of atory or other place			c. Location - City or	
Ĕ	Pag ment ant: I ury o		4 Donation 5 Other (Specify,		Kwood	cem.	1 2/2	7/06	BAlto. Mi	1
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Licens	99	22	Name and Address	ss of Facility	+1 Home	PA	
Ш	205 8 9		faul 711.	Stella	75	27 harfor	1 10 - 13	A Ito IND	21534	
			23a. Party. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. ne cause on each line.	Do not ente	r the mode of dyin	g, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Finat disease or condition resulting in death)	a. DEMENTIA						Oriset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):					
		-	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conseque	nce of):					
×	ted	듵	Cause (Disease or injury	200 (0) (0) 00 00 00 00 00 00						
-	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					
760,	death certificate be executed e attending physicien and od for use as the burial-transit	-1		d.						
6876	ificet g phy as the	edic								
Вох	h cert andin use	≥	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d		Ectopic pregnancy			23d. Date of de	ivery
B.	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of dea		Other (specify)	·		Month	Day Year
P.0	that the de led by the a detached f	by Physician/Medica	9 Unknown							
Ś	signed I		Part II. Other significant conditions co	ntributing to death but not resulti	ing in the un	derlying cause give	en in Part I.			the cause of death?
Records,	w requir been si should	ted			<del></del>			1 Yes	2 □ No 3 □ Pr	obabty 4 🛣 Unknown
ec	law 1es b e 2 st	ple						24a. Was an autopsy	prior to	topsy findings available completion of cause of
E	hysician: The law his certificete hes t I director, page 2 s	Completed						performe 1 ☐ Yes 2		2 No
Vita	ician Sertifi ector	Be	25. Was case referred to medicat examiner?	Hospital:		104	26. Place of Death	(Check only one)		
of Vital	Physician: The law requires that the this certificate has been signed by the director, page 2 should be detached.	٦.	1 ☐ Yes 2 M No	1 Inpatient 2 E	Outpatient  8b. Time of		4   Nursing Hon			cify) HOSPICE
	ding After fune	tlon	1 XNaturat 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury Work	Yes 2 No	8d. Describe how	injury occurred	
Division	I or Attending after death. Director: After I in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of trijury - At hom	e, farm, stre			Bf. Location (Stree	et and Number or Ri	ıral Route Number
οŚ	after after Dirs	Certification:	4 Homicide determined	building, etc. (Specify)		or, ractory, direct		City or Town,		rai i i obio i i bini boi,
	spits hours nera y fille		29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	edge, death	occurred at the tim	ne, date and place, ar	nd due to the cau:	se(s) and manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exami	ner: On the basis of examinatio and manner stated.	n and/or inve	estigation, in my op	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	To t withi To tll	Ž	29b. Signature and title of certifier			29c. License	e number	29d	. Date signed (Mont	h, Day, Year)
)			10-			1	13725		2/23	106
	9	Ì	30. Name and address of person who o	ompleted cause of death (ttem 2	За) (Туре, Р	<i>'</i>				
	U		DR. TARIQ MAHMOOD	2300 DULANEY		Y RD. T	IMONIUM, M	D 21093		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	θ					

			Please I	State of Ma		d / De	partment	t of H	eaith and M	_		egible.	000000
			State Registrar			C	ertificate	e of L	Death		Reg. No.	JUb	16091
	Physicia	an 🏻	1. Decedent's Name (First, Middle, Last)	MOZINO	40					2. Date of Dea Month	Day	Year O6	3. Time of Death 7:53 PM
	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location of Death	·	4c. Co	unty of Death	
			Anne Arundal Medical	Center				apoli				ARUNDAL	
H	Funeral Director		5//-52-48/2		(In yrs. la	ast birthda Yrs.	Months		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	v. Year)		place (State or Foreign ntry) ngton, DC
2	3 ≥	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or	Location						10d. Inside City Limits
April	ohe la	ō	Maryland Anne Arunda	.,		polis							1 Yes 2 No
A of	288	ect	10e. Street and Number		Millia	ports	10f. Zip	Code			10g. Citizer	n of What Cou	ntry?
di <sub>s</sub>	3a or	Funeral Directo	3822 Mockingbird Court					21401		l	Jnited	State An	erica
400	ms 2	Jera	11. Marital Status	12. Was Decedent E	ver in U.S	S. 1	3. Was Deced	lent of Hi	spanic Origin? (Sp	ecify Yes or No	14.	Race - Ameri Black, White	
21215-0036 d within 72 hours after death with the Manufacd	in remove area dean win no waysa. "natural", or items 23a or 28a-1 show indical Exercity frame the rediffied at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1√ Yes 2 □ No If Yes, Give Year or Dates:	0 1962 1964	to	1 Yes, spec		n, Mexican, Puerto Specify:	nican, etc.)	Sp		etc. hite
	natur.	ted	15. Decedent's Edu (Specify only highest grade	cation		16a. De	cedent's Usua	al Occupa	ation during most of work	ina	16b. Kind	of Business/Ir	dustry
d 21215 b	- Wad	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	+)	life	DO NOT us	se retired	)	9			
	tal Hygiene. d other then	Co	9			Ro	oute Sal	esman	18. Mother's Nam	a /First Middle	Priv		
ē (	2 7 5 C	Be	17. Father's Name (First, Middle, Last)								Maioeri 3u	mame)	
2 2	snould be and Mental s marked o umatic eve	P.	Stanley Mozingo  19a. Informant's Name/Relationship (Ty	na Print)		19h M:	ailing Address	(Street :	Eleanor Ad and Number or Run		er City or Ti	own State Zi	n Code)
Maryland	th and		Jessica Prudencio/daug						Silver Spr		-		, 4550/
و ج	Heall Heall em 2		20a. Method of Disposition		20b. Pl	ace of Dis	sposition (Nan	ne of		Date		tion - City or T	own, State
altimore,	permit. Pages I ario 2 should be Department of Health and Menti- Importent: If item 27 is markent any injury or other treumatic e gace.		1 Burial 2 Cremation 3 F	emoval from State	-		riematory`or o Washind		<sup>θ)</sup>   March Crematory	2, 2006	Laurel	, Maryla	nd
	artme orten injur		21. Signature of Funeral Service Licens	99	, od i		~		ss of Facility F1				
B B	Departition of the control of the co		1 hour & h	Mh.					pring Road				
30	- 4		23a. Part1 Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the death	. Do not	enter the moo	e of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
×. P	hysician		Immediate Cause (Final disease or condition	Veint	rice	lar	- fibr	11/2	tion				Onset and Death
3	/Medical		resulting in death)	Due to (or as a	consequ	ience of):	122	1 1100	,				
E	Examiner		Sequentially list conditions	ische	Mic	- ca	rdion	nyo	pathy				
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	and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a	CONSE	ence of):	Tery o	ohse	ase				
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				J									
Box	The law requires that the death centilicate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o							230	d. Date of deliv	rery
മ്	atter d for u	ciar	in the past 12 months?	1□Live birth 4 4□Pregnant at t			3 ☐Ectopic pr 5 ☐ Other (sp					Month	Day Year
O	res that the de signed by the a be detached t	hysi	9 Unknown	9 Unknown									
ر در	ned i	by P	Part II. Other significant conditions co	ntributing to death bu	it not resi	alting in th	e underlying c	ause giv	en in Part I.	23e. Did t	obacco use		the cause of death?
ğ	w require been sig should b		Hypertension							10	Yes 2□1	No 3 Pro	bably 4 Unknown
Records,	law requase been 2 should	Completed	Dyelipid	emia						24a. Was			opsy findings available ompletion of cause of
ž į	The lay	E								perfo	rmed?/	death? 1 ☐ Yes	
Vital	Pnysician: In this certificate ral director, pag	Bec	25. Was case referred to medical examiner?						26. Place of Deat	th (Check only o	one)		
	nysic his ce Il dire	2	1 □ Yesr 2 2No	Hospital: 1 Inpatier		ER/Outpa			4 🗆 Nursing He	ome 5 Resi			ify)
טע	ning Phys n. After this funeral di	ino ii	27. Man or of Death 1 ✓ atural 5 ☐ Pending	28a. Date of Injur (Month, Day	Yeer)	28b. Tim Inju	ry	28c. Injur Wor	k?	28d. Describe	how injury o	occurred	
sio	lendi Jeath tor: A the fi	cati	2 Accident investigation 3 Suicide 6 Could not be	28e, Place of Inju	in. At he	mo farm	M street feeten		Yes 2 □ No	28t Location (	Street and f	Vumber or Ru	al Route Number,
Division of	or Attendate atter death	Certification;	4 Homicide determined	building, etc			, street, ractory	y, onice		City or To	wn, State)	VO///DO/ O/ / 10/	arriodio riombor,
;	Hospite 24 hours Funeral tely tiller	Medical C		rsicien: To the best of iner: On the basis of and manner sta	examina								
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,	0		plustone	S. Las	rio		w	1	41034		Felm	uares 2	5 200/-
\l	) "		30. Name and address of person who c									1	, = -0
_/	8		SALVATORE S. LA				DRIVE	541	TE 300 A	WNAPOLIS	MD	2140	/
	Sta		31. Date filed (Month, Day, Year)  MAR 0 1 2006	2. Registra	ar's Signa	ture	arth 1			/			

			1 - For State Registrar	State of M	laryland / [	Depa <i>Cer</i>	irtment of F tificate of	lealth and <i>Death</i>		gien Reg. N	2006	06058
			1. Decedent's Name (First, Mic	ldle, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medio		Virginia Ann	Mooney					Febru	ary	26 2006	1:20A M
);	Examir		4a. Facility Name (If not institut	ion, give street and number,	)		4b. City, Town, o	or Location of Dea	ith	4	c. County of Death	
			Gilchrist Hos	*			Tows				Balti	
н	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	th y, Year		place (State or Foreign intry)
	Director		026-34-8034 Usual Residence of Decedent	A	59	113.			June 1	4,19	946 <u>Mas</u>	sachusetts
	land ow		10a. State 10b. Cour	ity	10c. City, Tow	n or Loc	cation					10d. Inside City Limits
	Man Frsh fied	to	Maryland How	ard		(	Columbia					1 ☐ Yes 2 No
	r 288	irec	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?
	th wit	Funeral Director	9583 Standon	Place			210	045			U.S.	Α.
	dea .	ner	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. ?	13. V	Vas Decedent of h Yes, specify Cub	fispanic Origin? ( an, Mexican, Pue	Specify Yes or No into Rican, etc.)	)-	14. Race - Ameri Black, White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show sty injury or other traumatic event, the Madical Examinar hast be notified at once.	b	1 □ Never Married 2 ☑ M 3 □ Widowed 4 □ Divorc	arned 1 ☐ Yes 2 ☐	₹No		☐Yes 2∏X No		,		Specify:	hite
5-0	72 hc	Completed		ent's Education rest grade completed)	16a.	Deced	ent's Usual Occup	pation during most of w	orking	16b. i	Kind of Business/Ir	ndustry
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2	filed withi Hygiene. other ther	S	12	4	R	egis	stered N		(Fi Middle	1 do 1 do	Health	Care
and	be fi	Be	17. Father's Name (First, Middle William Davi						<sub>ame (First, Middle</sub> ce Manso:		n Sumame)	
<u>~</u>	should nd Men marke umatic	T <sub>o</sub>	19a. Informant's Name/Relatio		10h	Admilia	a Address (Street				or Town, State, Zij	n Cada)
Maryland	d 2 sh th and 7 is n traun		Richard Mooney		1						ary1and 2	
	1 and Health Iom 27		20a. Method of Disposition	(Husballu)	20b. Place of	f Dispos	sition (Name of	1	Date		Location - City or T	
JOH	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	n 3 Removal from State	9	-	natory`or other pla ematory		1-2006	Cat	onsville	, Maryland
Baltimore,	permit. F Departme Importar eny injur		21. Signature of Funeral Service	e Licensee		22	Name and Addre	ss of Facility			,011011110	, naryzana
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					ed the death. Do						, , , ,	Approximate Interval Between Onset and Death
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	/Medical Examiner		, southly are south	Due to (or as	s a consequence	of):						U
	÷	e	Sequentially list conditions,	b. Due to (or as	e a soneuquense	of):						
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ď	exec an an	Exa	resulting in death) Last	Due to (or as	s a consequence	of):						
68760,	ficate be executed physician and s the burial-transit	edical Examin		d								
	ing ph		IF FEMALE:									
Вох	eath certiff attending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnanc	y /			23d. Date of deliv Month	very Day Year
P.O. I	law requires that the death certificate be execu as been signed by the attending physician and 2 should be detached for use as the burial-tra	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregnant a 9□ Unknown	at time of death	5 🗆	Other (specify) _	2	2			
	s that ned b e deta	by Pt	Part II. Other significant cond	itions contributing to death	but not resulting in	n the un	iderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to t	the cause of death?
of Vital Records,	quire an sig								10	Yes 2	2 Proi	bably 4 Unknown
000	awre s be 2 sho	Completed							24a. Was		24b. Were auto	opsy findings available
Ä	o = 0	ĕ							perfe	ormed? 2 ⊠N	death?	
ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medi examiner?	cal	ienicae			26. Place of De	eath (Check only	one)		
× ×	Physic this ce al dire	ျ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat		_	3 DOA		Home 5 ☐ Resi		6 A ther (Speci	m Hospice
	ing P Viter t unera		27. Manner of Death 1 X Natural 5 ☐ Pen	28a. Date of Inj (Month, D	ury 28b. ay Yea <i>r)</i> I	Time of Injury	28c. Inju		28d. Describe	how inju	ury occurred	g .
sio	Attending it death.  ector: After by the fune	cati	2 Accident inve	stigation				Yes 2 ☐ No	0011			10
Division	after of Direction by	Certification:		mined 289. Place of It	njury - At home, fa atc. <i>(Specify)</i>	arm, stre	et, factory, office		City or To		and Number or Rur te)	ar Houte Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely tilled in by the funeral	edical C	(Check only 2 Medic	ying Physician: To the bes al Examiner: On the basis								
	To the li within 2. To the I	Med	one) 29b. Signature and title of cert	and manner s	stated.		29c. Licens	<u> </u>			ate signed (Month,	
	D is C		M An	hong Re	en. m	0	02	5205			Δ.	26,2006
	10		30. Name and address of pers	on who completed cause of	death (Item 23a)	(Type, I	Print) n	40	21		21204	
	٩		W. A. Rile	1 6 BMC	6701 N	1-0	haves I	T. Bol	to. M.C	1 5	21204	
	Sta		31. Date filed (Month, Day, Ye		trar's Signature	A	Carl B					
Dis	Regist		MAR (	) 1 2006	Silver Alla	9						
DΗ	MH 17 Rev 1/2	:001				1 100						

Mooney, Virsinia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg, No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:15 A M 23-2006 rion /Medical 4c. County of Death 4b Ciro Town or Location of Death Facility Name (If not institution, Examiner Baltimore atonsu Nood n yrs. last birthday) Date of Birth (Month, Day, If Under 1 Ye Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 244-18-4429 1 M 2 F Director Usual Residence of Decedent the Maryland 10a State 10c. City Town or Location 10d, Inside City Limits 10b. County other traumatic event, the Modical Examiner quet be nutified at Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA Itams 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is markad othar than "natural", or Itar 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BCC Completed by 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life) DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) of Bu more ondary (0-12) College (1-4or 5+) eria Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Numb) Distorm 1112 permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trai once. 20b. Place of Disposition (Name of cometery, crematory of other p 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Ustown, m 21133 Approximate Interval Between Onset and Death 23a. Part1. Ent v e disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Year Month Dav 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an certificate has autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 🗌 Yes 2 3 No 1 Inpatient 2 ER/Outpatient 3 DOA 0 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After t To the Hospital or Attanding 5 Pending 1 Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D 29a Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 027569 of death (Item 23a) (Type, Print) 30. Name and address 21200 Grune eman 32/Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

MAR 0 1

2006

			Please 1	Type or Print in Bl	ack Indelible Ink	. Ensure All	Copies Are	e Legible.	
			1_ For State	State of Maryland			ental Hygier	enns	06060
			1 State Registrar  1. Decedent's Name (First, Middle, Last	)	Certificate of	Death	Reg. N	to. U U U	3. Time of Death
	Physici /Medi		John T. M	cClain:	Jr			Day Year 1 22, 2006	11:25 M
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	or Location of Death	-	c. County of Death	1
	Funeral		5. Social Security Number 6. Se		ce I M st birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		217-18-7273 1 Usual Residence of Decedent	ÓM 2□F 83	Yrs. Months Days	Hours Min.	Feb. 19, 19	723 Ma	ryland
	yiand yiand		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	8a-fe	Director	Maryland N/A	Bo	altimore				1 X Yes 2 No
	be filed within 72 hours after death with the Maryland stal Hygliene. ed other then "naturel", or flems 23s or 28s-f ehow event. The Modified Examiner must be notified at	Dire	10e. Street and Number	Lunta, Pl.	10f. Zip Code	515	10g. (	Citizen of What Cou	untry?
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	dispanic Origin? (Spe	cify Yes or No-	14. Race - Ameri	
36	s after	by Fu	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	1 ሺ Yes 2 □ No If Yes, Give	1 ☐ Yes 2 ☑ No		rican, etc.)	Black, White	, etc.
Maryland 21215-0036	72 hour naturel		15. Decedent's Edu	Year or Dates:	16a. Decedent's Usual Occup	pation	16b.	Kind of Business/Ir	ndustry
121	within 7 ene. then "n	Completed	(Specify only highest grad	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of workii	ng Y	2 . 1 1	000.
d 21	Hygier ther the		17. Father's Name (First, Middle, Last)	4	Man Har	18. Mother's Name	(First, Middle, Maide	OST ( en Sumame)	Ittice
lan	should be nd Mental marked c	To Be	John T. McC	Vain Sr.		Anna	Dor	sev	
Mary	S is a		19a. Informant's Name/Relationship (7)	rpe, Print) (Son)	19b. Mailing Address (Street	and Number or Rura	l Route Number, City	-	p Code)
	s 1 and f Health item 27 other tr		20a. Method of Disposition	CClain 20b. Plac	5 410 CTOS  ce of Disposition (Name of	, D	ry Blud	Location - City or T	Nd, 21215
E	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	netery, crematory or other pla COSOO FOO	3/3/	2006 A	Ninne M	lille Md
Baltimore	permit. Pages Department of Important: If it eny injury or o		21. Signafure of Funeral Service Licens		22. Name and Addre	ss of Facility	Hland	DINGS PA	1115,110.
	₫ O 등 ■ Ø		23a Part Enter the drease or compl	The Report of the death	2222 W. N	orth Ave	Balto.	Ma 212	Approximate
	Physician		23a. Part / Enter the disease, or comol shoety, or heart failure. List only of Immediate Cause (Final			ig, such as cardiac of	respiratory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequent					
	Examiner	70	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	nce off:				
W	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	nce or).				
· 09	be executed ician and burial-transit	ai Exa	resulting in death) Last	Due to (or as a consequen	nce of):				· · · · · · · · · · · · · · · · · · ·
6876		dica		d					
Box (	death certificate I e ettending physi id for use as the t	In/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance				23d. Date of deliv	ery
	0 00 0	by Physician/Medica	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown		y 		Month	Day Year
Δ.	The law requires that the disterning has been signed by the page 2 should be detached	/ Ph	Part II. Other significant conditions con	ntributing to death but not resulti	ng in the underlying cause giv	ren in Part I.	23e. Did tobacco	o use contribute to t	the cause of death?
Vital Records,	w requires been sign should be	ed pa					1 ☐ Yes	2 □No 3 □ Pro	bably 4 Munknown
eco	e lawre has bee	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
							performed? 1 ☐ Yes 2 🛣 N	death?	
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient 3□ DOA Oth	26. Place of Death	Check only one	6 Y Other (Speci	(y) HOSPICE
Division of	ng Phys fter this ineral di		27. Manner of Death 1 Manual 5 ☐ Pending		Bb. Time of lnjury Wor		8d. Describe how in		most ice
isio	ttendi death. ctor: A / the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	M 1 🗆	Yes 2 □No	8f. Location (Street a	and Mumbas as Rue	al Courte Number
<u>S</u>	s after s after ii Dire	Certification:	4 Homicide determined	building, etc. (Specify)	o, iaini, street, factory, omce		City or Town, Sta		ai noute Number,
	To the Hospital or Attending Phy within 24 hours atten death. To the Funeral Director: After this completely filled in by the funeral or		(Check only 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination	edge, death occurred at the time	me, date and place, a	nd due to the cause(	s) and manner as s	stated.
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated.	29c. Licens			Date signed (Month,	
	->-0		112	positivity In	Dy	3725		2/22/5	
	1/4		30. Name and address of person who co		3a) (Type, Print)	19			
	Sta	te	DR. TARIQ MAHMOO  31. Date filed (Month, Day, Year)	D 2300 DULANES  32 Registrar's Signatur	0 4	TIMONIUM,	MD 21093		
	Registr		MAR 0 1 2006	States St.	park	<u></u>			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1834 February 17 2006 ugene /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1timore Johns Hopkins Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 🗆 🗶 1 2 🗆 F Yrs. 229-30-4046 **NEW YORK** 77 Jan 29, 1929 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f ehow the Medical Examiner must be notified at 1 Nes 2 No BALTIMORE MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 1225 N. LUZERNE AVE U.S.A 21213 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 □XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify Black δ 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) STEEL Elementary/Secondary (0-12) College (1-4or 5+) PIPE MILL 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked off jury or other treumatic even Be EUGENE McCOY GRACE JOHNS STOKES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1221 LUZRENE BALTIMORE, MD 21213 ROSIE McCOY Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition → Removal from State Department of Important: If any injury or pace. 02/22/06 **MARYLAND** TRINITY CEMETREY 5 Other (Specify) 21. Signature Funeral Service 22. Name and Address of Facility Miller"s Metropolitan Chapel P.C. 1639 North Broadway Baltimore , Maryland 21213 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Ente shock, a Immediate Cause (Final disease or condition resulting in death) Metasto **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitet or Attending Physicien: The law requires that the death certificate be executed **burial-transit** and Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No X 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on 1 Yes 2 Other: ( In atient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Da e of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death

1 atural
2 Accident 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death investigation within 24 hours after death To the Funeref Director: completaly filled in by the 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 000 Medical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600N Wolfe St BULL, MD 21287 Hospital Channing The Johns Paller MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 6 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 7:32AM February 27, W. Neuhauser Harrison /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Nursing & Rehab. Center Westminster If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) May 21, 1918 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□ F 87 Director 217-09-2365 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Export is traumatic any once. 10a State 10b. County 1 ☐ Yes 2 ☑ No Director Owings Mills Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117 12411 Timber Grove Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical U S Post Office 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harrison M. Neuhauser Minnie Horn 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12411 Timber Grove Road, Owings Mills, MD 21117 Wife Helen C. Neuhauser 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 3/3/06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 Con Approximate Interval Between Onset and Death Flant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm mate Cause (Final Physician 7167EARS disasse or condition raulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physiclan/Medical use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ٥ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2 No 1 Yes or Attending Physician: in by the funeral director, 26. Place of Death | Check only one Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat ineral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide within 24 hours at To the Funeral D completely filled in To the Hospital 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) n59552 30. Name and address of perso who ompleted cause of death (Item 23a) (Type, Print) LOUPLISHANTAC POOLE MA Cognord 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		Please Amend unpend it Justan State Registrar			ertificate of		Reg.	/ 1111	6 U6U6
Physicia	an	1. Decedent's Name (First, Middle, L George C. Neiber:	lein. JR.				2. Date of Death Month FEBRUARY	Day Ye	
/Medic	al	George Neiber  4a. Facility Name (If not institution, g	<del>lein</del>		4b. City, Town,	or Location of Death		7, 2006	
Examin	er	200 E. PATAPSCO			BALTI	MORE			
Funeral Director		5. Social Security Number unk 6.	Sex 1 M 2 ☐ F	e (In yrs. last birthda 42 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Nov 11,	ar) 1963	Birthplace (State or For Country) un
<b>*</b> 000		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location				10d. Inside City Lin
ıtal Hygiene. od other than "natural", or iteme 23a or 28a-f ehow avent, iha Medical Examinar musi be notifiad at	ō	MD		Baltimon					1√ Yes 2□
7.289	Funeral Director	10e. Street and Number		1	10f. Zip Code		10g.	Citizen of What	t Country?
क्या है	al D	200 E. Patapsco	Avenue		2122	25		IISA	
BL D	iner	11. Marital Status unk	12. Was Decedent Armed Forces?	Ever in U.S. 13	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spectan, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - A	American Indian, Vhite, etc.
dma	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No dire	1 ☐ Yes 2 🔀 No	Specify:		Specify:	white
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	Completed	unk	unk	54,		,			
c avent	Be	17. Father's Name (First, Middle, Las	st)		unk	18. Mother's Name	(First, Middle, Maid	den Sumame)	u
other traumatic ave	P.	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Stree	t and Number or Rural	Route Number, Ci	ty or Town, Sta	te, Zip Code)
other tr		O.C.M.E.			Penn Str		ore, MD	21201	or Town, State
		20a. Method of Disposition  1 Burial 2 Cremation 3	☐Removal from State	cemetery, c	rematory or other pla		200	. Location - On	or rown, state
eny injury or once.		4 ☐ Donation 5 ☑ Other (Special Signature of Funeral Service Lice			22. Name and Addr	ess of Facility			
eny l		Ronald S		ector	State Ana Baltimore	tomy Board	655 W. 1	Baltimo	re Street
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or, page 2 shoul	<b>Completed</b>		I to a citate	ent 2 ER/Outpat	tent 3 DOA	ab		e 6 NOther (	Specify) SCENE
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To the Funeral Director: Atter this certiticate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be	examiner?  1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending investigat 3  Suicide 6  Could no determine  29a. Certifier 1  Certifying (Check only 20 Medical Ex	28a. Date of Inju (Month, Date of Inju (Month, Date of Inju the od 2/7/20 28e. Place of Inju building, e CONCRETE Physician: To the best aminer: On the basis of	28b. Time Injur 2006 Fnd 3 jury - At home, farm, tc. (Specify) walkway tof examination and/or	28c. In W 245 1 15 street, factory, office eath occurred at the investigation, in my	time, date and place, a opinion, death occurrense number	Bluratures 8f. Location (Stree City or Town, S Baltimore and due to the caus d at the time, date	t and Number of tate) 200 E. MD e(s) and manne and place, and	or Rural Route Number, Patapsco Ave er as stated. due to the cause(s)
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		-	State For State Registrar		artment of Health and I rtificate of Death	Mental Hygien	PHUG ACACL	
<b>₹</b>	Physicia	an	Decedent's Name (First, Middle, Last)     ANITA		NEEDLE	2. Date of Death FEBRUARY	3. Time of Death 7:00 A M	
	/Medic Examin		4a. Facility Name (If not institution, give street and 3700 CLARINTH ROAD	number)	4b. City, Town, or Location of Death		Ic. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Yea APR. 4,19	9 Rintholace (State or Foreign	
	D.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits 1 \overline{\mathbb{N}} Yes 2 □ No	
	the Ma	Funeral Director	MD N/A  10e. Street and Number	BAL	TIMORE 10f. Zip Code	10g. C	Citizen of What Country?	
	ath with	raiD	3700 CLARINTH ROAD	12	21215		USA 14. Race - American Indian,	
036	hours after death with the Maryland turel', or Itema 23a or 28a-f ehow al Examiner must be notified at	by	1 Never Married 2 Married 1 Yes	s 2 X No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White, etc.  Specify: WHITE	
21215-0036	in 72	Completed	15. Decedent's Education (Specify only highest grade completed in the comp	ed) (Give	dent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	rking	. Kind of Business/Industry  MEN'S CLOTHES	
nd 2	2 should be filed with and Mental Hygiene. Is marked other that aumatic event, the	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, Maide	en Sumame)	
Maryland	should to and Ment marked umatic	၉	ISAAC  19a. Informant's Name/Relationship (Type, Print)		INGSTON MOLLI ing Address (Street and Number or Ru		KAPPALMAN y or Town, State, Zip Code)	
	and 2 fealth a m 27 is		ELLEN HIMELFARB / DAL	IGHTER 720	4 VERBENA ROAD –		MD 21209 Location - City or Town, State	
altimore,	Pages nent of hunt: If Ite		1 X Burial 2 ☐ Cremation 3 ☐ Removal fi 4 ☐ Donation 5 ☐ Other (Specify)	om State cemetery, cre	matory or other place) UNAH AITZ CHAIM 2		ALETHORPE, MD	
Balti	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic <u>pnce</u> .		21. Signature of Funeral Service Licensee	ttle	8900 REISTERSTOWN	ROAD - PI	N & BROS., INC. KESVILLE, MD 21208	
	Physician		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	on each line.	Iter the mode of dying, such as cardial $ARYARTER$		Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between	
	/Medical Examiner			e to (or as a consequence of):				
(a)	uted J Ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e to (or as a consequence of):				
7.092	ate be executed hysicien and the burial-transit	cal Exa		e to (or as a consequence of):				
.O. Box 68	death certific e attending p id for use as i	Physician/Medl	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
S, D	uires that t n signed by	þ	Part II. Other significant conditions contributing	to death but not resulting in the			accoluse contribute to the cause of death?	
I Record	The larate has	Completed				24a. Was an autopsy performed 1 Yes 2		
Vita	Physician: The I this certificate har ral director, page	To Be	25. Was case referred to medical examiner?  1  Yes	1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	ath (Check only Me) Home 5 Residence	e 6 ☐Other (Specify)	
on of	iing Phys 1. After this funeral di		27. Manner of Death 28a. I	Date of Injury Month, Day Year) 28b. Time Injury		28d. Describe how in	njury occurred	
Division of Vital	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:		Place of Injury · At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)	
	• Hoapital 24 hours a • Funeral letely filled	edical C	(Check only 2 Medical Examiner: On	o the best of my knowledge, dea he basis of examination and/or i manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause surred at the time, date	a(s) and manner as stated. and place, and due to the cause(s)	
<b>\</b>	To the within 2 To the comple	Me	29b. Signature and title of certifier	Au	29c. License number 000/93 (	29d.	Date signed (Month, Day, Year)  27166	
	10		30. Name and address of person who completes  Constant to the constant to the completes  Constant to the constant to th	cause of death (Item 23a) (Type	5: 3	Inder	nD 21208	
4.00	St Regist	ate	31. Date filed (Month, Day, Year)  MAR 0 1 2006	32. Registrar's Signature	Corle		t	

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State of Ma	-	epartme <i>Certifica</i>			and Me		giene Nog. No.	006	06065
	Dhusiai		1. Decedent's Name (First, Middle, Las		1.				2	Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic	al	Dolores		ecusk		Tours or	r Location o	of Death	2	27 40 COI	2006 unty of Death	12.30 PM
	Examin	er	4a. Facility Name (If not institution, give Johns Hopkins B	XIVIEW ME	edical C	4		timo				I/A	
	Funeral Director		5. Social Security Number 6. S		(In yrs. last bir		der 1 Year s Days	If Under a	Min.	Date of Birth (Month, Day	, Year)	9. Birthp Cour Mary	
	D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location				-		1	0d. fnside City Limits
	faryla et at	ō	MAryland Baltimon	~e	-	dalk							1 ☐ Yes 2X No
	the M	Director	10e. Street and Number				Zip Code				10g. Citizen	of What Cour	ntry?
	h with 23a or ist bu		7527 Holabird Aver	nue			21222	?			USA		
	ems :	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was De If Yes, s	cedent of H	lispanic Orig	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	14.	Race - Americ Bfack, White,	
36	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f ehow tha Madical Examinar must be moliffed at	by Fu	1 ☐ Never Married 2 ☐ Married  3X☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N ff Yes, Give Year or Dates:	0	1 □ Yes	21 <b>X</b> No	Specify:			Spe	ecify: Wh:	ite
9	2 hou	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a.	Decedent's U (Give kind of	sual Occup	ation	t of working	,	16b. Kind	of Business/In	dustry
2	vithin 7	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5	+)	life. DO NO	use retired	d)		<b>'</b>	M	- TJ	
2	Hygier ther then the		8 years 17. Father's Name (First, Middle, Last)			Waitre	ss_/	Barma 18. Mothe		First, Middle.		e Lodge	2
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene 1 hours afterns 23a or 28a-f ehow item 27 is marked other than "natural", or items 23a or 28a-f ehow other transities result to notified at	To Be	William Siebert					Mar	tha D	embeck			
ary	and N	. 1	19a. Informant's Name/Relationship (	** *		. Mailing Addr							
	1 and Health In 27		Robert J. Olszews  20a. Method of Disposition	ski son		Lerne: Disposition (I			Da	te	-	nd 212	
nor	Pages nent of h ant: if ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemete	ry, crematory o	r other plac	ce) [	March 2006	•			ty, MD.
Baltimore,	permit. Pages 1 Depertment of H Importent: If ite any injury or of		21. Signature of Funeral Service Licer			22. Name	and Addre	ss of Facilit				lk,P.A.	
8	88 = 58			رحسا		7110	Soll	ers Po	oint 1	Road, 1	Dunda]	lk,Md.	21222 Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only fmmediate Cause (Final	one cause on each lin	the death. Do	•	1.		cardiac or	respiratory ar	rest,		Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a	nary	Emb	olisi	n					1 month
	Examiner		Sequentially list conditions	, Deep	Vein	Throi	n bos	sìs					3 months
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as	a consequence	of):							
( 	axecut	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):							
8760,	cate be executed physicien and the burial-transit	dicai	(	d									
9	ertifica ling ph	/Med	fF FEMALE:	23c. ff yes, outcome	of programmy							Date of dally	
Вох	w requires that the death certific been signed by the attending p should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetaf death	3 ⊟Ectopi 5 ⊟ Other		у			230	. Date of deliv Month	ery Day Year
P.0.	it the d by the tached	hysi	1 ☐ Yes 2 XNo 9 ☐ Unknown	9□ Unknown									
	The law requires that the tite hes been signed by the bage 2 should be detache	by P	Part fl. Other significant conditions	1.	1	. 011	g cause giv	ven in Part I	l.	23e. Did t		4	he cause of death?
Sorc	r requi	eted	Emphysema, c		hear		of the			24a. Was			opsy findings available
Rec	e tar hes	Completed by	atrial tibrillat	ion, care	KIO MY C	parny	, ay	spria	910	autor		prior to co death?	impletion of cause of
ita		BeC	25. Was case referred to medical					26. Place	e of Death	(Check only o			
of V	× 5	은	examiner? 1 Tes 2 No	Hospitaf:			DOA					Other (Speci	fy)
ou	Attending Physician: r death. ector: After this certific by the funeral director,	tion:	27. Manner of Death  1 Naturaf 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of fnju (Month, Da		Time of Injury M	28c. Inju Wo	rk? ]Yes 2. ☐		8d. Describe I	now injury o	ccurred.	
Division of Vital Records,	I or Attending Ph after death. Director: After th I in by the funeral	ertification;	3 Suicide 6 Could not be determined	9 28a Place of Ini	ury - At home, fa	arm, street, fac	tory, office		21	8f. Location (		lumber or Rur	al Route Number,
	pitel o	O	200 Continue (M. Contituing Di	avelejas. Ta the best	of my knowledg	e death essur	rad at the tr	mo data as	ad place as	ad due to the	201100(0) 20	d manner as	etaled
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edicai	29a. Certifier 1 X Certifying Pl (Check only 2 Medical Examone)	nysician: To the best miner: On the basis of and manner sta	examination ar	nd/or investiga	tion, in my	opinion, dea	ath occurre	d at the time,	date and pla	ace, and due	to the cause(s)
	To the To the To the Comp	Ň	29b. Signature and title of certifier				29c. Licen:		-		29d. Date s	igned (Month,	Day, Year)
	$\chi$		r some /s	eous	nath /ltom 22-1	(Type Print)	ודע	805	•		2101	100	
	11		30. Name and address of person who Steve Georgs	m7 40	IN FOOT	Dea Alle	nue, 1	Baltir	nove	MD	2123	14	
6		ate	31. Date filed (Month, Day, Year)	32. Hogistr	ar's Signature	A. a. B	9 9						
	Regist	rar	MAR 0 1	ZUUD	المكر صلا	1000	100						

 $\mathcal{P}M$ 06-01416 Alvina Prosser

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	110550	_	1 - For State Registrar	State of	of Maryla		partment of ertificate of		l Mental Hy	giene Reg. Nö.	06	060	66
	Dharaisi		1. Decedent's Name (First, Middle	le, Last)			-		2. Date of De	eath	Vana	3. Time of	
	Physici /Medic		Alvina Anna Pr	rosser					Februa	ry 25,	2006	10:08	$\mathbf{A}^{M}$
	Examin		4a. Facility Name (If not institution		,	T.		or Location of De	ath	4c. Co	unty of Death		
			8101 Ridgetown					kville				imore	
	Funeral Director		5. Social Security Number 218–28–3525	6. Sex 1 □ M 2 <b>X</b> F	7. Age (in y.	rs. last birthda Yrs.	Months Day			1930		place (State of intry) yland	r Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c.	City, Town or	Location					10d. Inside Cit	ty Limits
	Mary f ehc	Ď	MD Bali	timore	Ι,	Parkvil	10					1 ☐ Yes	-
	r 28a	Funeral Director	10e. Street and Number	CIMOLE		arkvii	10f. Zip Code			10g. Citizen	of What Cou	intry?	
	h with	0	8101 Ridgetow	n Drive -	Apt. F	3	21236	<b>5</b>		U.S.	Δ	•	
	eep su	ner	11. Marital Status		edent Ever in		Was Decedent of	<u> </u>	(Specify Yes or No	p- 14.	Race - Ameri		
36	or It	E.	1 X Never Married 2 ☐ Mar	ned 1 X Yes	2 TNotre	am.	1 ☐ Yes 2X N		orto riloari, otc.)		Black, White, ecity:	, etc.	
Ö	ure!,	d by	3 ☐ Widowed 4 ☐ Divorced	Year or L	Dates: Erc						Whi		
21215-0036	within 72 hours efter deeth with the Maryland ene. then "naturel", or Items 23a or 28a-f ehow the Madical Examinar must be notified at	Completed	(Specify only highe	nt's Education st grade completed		(Gi	edent's Usual Dcc re kind of work don DO NOT use retir	e during most of w	vorkin <b>g</b>	16b. Kind o	of Business/Ir	idustry	
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פַ	e filec Il Hyg othe	ВеС	17. Father's Name (First, Middle,	Last)			TCT IV	18. Mother's N	lame (First, Middle			Depart u	ileric_
/lar	uld by Menta Menta irked	To E	Louis Prosser					Mary E	E. Facket	:t			
Maryland	2 sho and 1		19a. Informant's Name/Relations	ship (Type, Print)		19b. Ma	iling Address (Stree	et and Number or i	Rural Route Numb	er, City or To	wn, State, Zi	p Code)	*,,
≥,	end eelth m 27		Shirley P. L	ubinski (s			Box 519	9 - White		Maryla	ind 21	162-05	19
ore	ges 1 t of H if ite or otl		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 Removal from		cemetery, c	position (Name of ematory or other pi	lace)	Date	20c. Locati	on - City or T	own, State	
altimore,	t. Partmen		4 Donation 5 Other (5	•	Me		ematory,						
Bal	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Depertment of Heelth and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or Items 23a or 28a-f ehow emportant: other traumatic event, its Medical Examinar must be notified at once.		21. Signature of Funeral Service	Sch Orc	nack		22. Name and Add						P.A. 087
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that only one cause on	caused the de	eath. Do not e	nter the mode of dy	ying, such as cardi	ac or respiratory a	rrest,		Approximate	ween
)	Physician		Immediate Cause (Final disease or condition	- Deow	NING A	Sporis	TED WITH	ATHENOS	CUSTOTIC	CARDI	JVISOL	Onset and E	Seath
	/Medical Examiner		resulting in death)		(or as a cons					li l		,	
		-	Sequentially list conditions,	b	(or as a cons	equance of:							
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9	tifical ng phy es th	Medi		8=30									
Вох	death certific e attending p id for use es i	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pred		□Ectopic pregnan	cv		23d.	Date of deliv		
ю. П	0 0 0	sici	in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at time o		Other (specify)				Month	Day Y	'ear
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ā	itcian: Th certificate rector, pag	ပိ	25. Was case reterred to medica						Yes	2□No		2 No	
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Division of	Attending Physicien: The law r death. c death. ector: After this certificate has b by the funeral director, page 2 si		27. Manner of Death	28a. Date	of Injury	28b. Time	ol 28c. Inj		28d. Describe			y) SCEE	
ion	ath. r: Aft	Certification:	1 ☐Natural 5 ☐ Pendir 2 ☐Accident investi	9	2-25-0		0 5 M 1	ork? □Yes 2 No	SUBJE	4 DR	0 W NE	n	
i≺is	r Atte	tific	3 Suicide 6 Could 4 Homicide determ	ained   289. Place	e ol Injury - A ling, etc. (Spe	t home, farm.	street, lactory, office	9	28t. Location ( City or To	Street and Ni	umber or Run	al Route Numi	ber,
	pital or ours efte leret Dir filled in I			В	ATH TU	BAT	HOME		8101 RID	GE TOWN		PARKVIL	LE MI)
	To the Mospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 ☐ Certifyii (Check only one) 2 ☐ Medical	ng Physician: To the Examiner: On the to and man	e best of my loasis of exam	nowledge, de ination and/or	ath occurred at the investigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and date and pla	d manner as s ce, and due t	stated. o the cause(s)	
	within To th compl	Me	29b. Signature and title ol certifie				29c. Licer	nse number		29d. Date si	gned (Month,	Day, Year)	
	141		1 Magne	The Us	reli	M	)	O.C.M.E		Februa	ary 26	, 2006	
	4'		30. Name and address of person  MARGAMOD D	who completed cau	se of death (I	tem 23a) (Typ 11:	e, Print) L Penn St	reet, Bai	ltimore,	Maryla	and 21	201	
19	Sta		31. Date liled (Month, Day, Year	) #2 !	Registrar's Sig	_							
	Registr		MAR 0 1	2006	1300 M		all s						
DH	MH 17 Rev 1/2	201				\$P							

Amend item#7, perFH, 0853/3/2/06 TI State of Maryland / Department of Health and Mental Hygiene () () 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Claire Louise Bolden Parker Feb 21, 2006 /Medical 8:20 Α 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Grand Heritage Unit Nursing Home Chevy Chase Montgomery If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F 579 40 1931 Director Aug 5, 1930 Rhode Island Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits The Medical Examiner must be notified at Completed by Funeral Director n/a Washington DC TX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1238 Franklin Street N.E. or iteme 23a 20017 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or ite ury or other traumatic event, in a Medical Examinal 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 African Specify: American 1 ☐ Yes 2 ☐ No Specify: 3(☐) Widowed 4 ☐ Divorced XX 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Librarian Dept of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Bolden 2 Celena Pearl Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Parker (Son) 361 Union Street, Doylestown, Pa 18901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Depertment of Important: If eny injury or Harmony Cemetery Feb 28, 2006 Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d mo0257 Alexandria Ferry Road, Clinton, MD bart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced paninah (cauce /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕾 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 Privo 2 ER/Outpatient 3 DOA this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054566 2/21/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1220 A 528+ ropparcol, Such 230 Town MALI 286 Sum the Blogaville 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR ( 2025 State Registrar

Pazdzienski, Wanda

				Please	Type or Pri					•		ble.	
			For State Registrar		State of M	arylan		artment of the tificate of	lealth and N Death		giene Reg. No.	16	06068
	Dhysisi		1. Decedent's Nam			ZDZ TI	NOUZT			2. Date of De Month		Year	3. Time of Death
	Physici /Medic		WANDA	EILE		ZDZIE	NSKI			02	24 2	506	4:19 PM
,	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of De  Rosedale  Baltin										C.0
П	Funeral		5. Social Security N	lumber / 6.8	Sex 7. Ag		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birthol	ace (State or Foreign
	Director		235-22-		1 ☐ M 2 🔀 F	8	0 Yrs.			8-25-1	925	WES!	VIRGINIA
poland	how		10a. State	10b. County	TMODE	10c. City	, Town or Lo		OCHDALE			10	Od. Inside City Limits
M ed	allife	ecto	MD 10e. Street and Nu		TIMORE				OSEDALE				1 ☐ Yes 2 💆 No
death with the Maryland	r Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at	Funeral Director		RON ROAD				10f. Zip Code	1237		10g. Citizen of W	hat Count	try?
deat	ems 2	Iner	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. V	Vas Decedent of h	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		- America	
DOUTS afte	r. or It	by FL	1 ☐ Never Marri 3 ☐ Widowed	ied 2∭ Married 4 □ Divorced	1 ☐ Yes 2 💆 If Yes, Give Year or Dates:	No		l □ Yes 2🏋 No	Specify:	, , ,	Specify		WHITE
	nature lical E	ted		15. Decedent's E	ducation			lent's Usual Occup	pation during most of work	-	16b. Kind of Bu		
d Z I Z I 3-0036	then "	Completed	Elementary/Seco		College (1-4or 5	5+)	life. L	SUPERVI	d)	n i g	नः एसए	PHON	E COMPANY
Z pelij	Hygie other ent, it	Be Co	17. Father's Name	(First, Middle, Last	) 4				18. Mother's Name	e (First, Middle,			
should be	Menta arked stic ev	To B	HERBERT		MONTGON	MERY			LELIA		(WH	ITEC	OTTON)
~	ls murranm		19a. Informant's Na		91				and Number or Run			_	Code)
1 and	Heait tem 2 other		20a. Method of Disp		ENSKI/HUSI	20b. Pl	ace of Dispos	AKRON Resistion (Name of		SEDALE,	MD 212		vn. State
Pages	nt: If i			☐ Cremation 3 ☐ 5 ☐ Other (Speci)	Removal from State			natory or other pla OF FAITH	CEM 2-28	-2006	BALTI		
Dailling	Department of Hear Important: If item 2 eny Injury or other 2005.		21. Signature of Fy	al Service Lice	offee		22	. Name and Addre	ss of Facility CV	ACH/ROS			
4	10 E E G	_	22a Barti Enter		plications that square	the death			ACO AVENU		EDALE, M		21237
Di	hysician		Immediate Cause	(Final	plications that caused one cause on each li	ne.	. Do not ente	ar the mode or dyn	ig, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
,	Medical		disease or condition resulting in death)		Due to (or as	a consequ	ence of):					-	
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be exec	icien and burial-translt	I Exa	resulting in death) I	Last	C. Due to (or as	a consequ	ence of):					-	
licate b	signed by the ettending physicien d be detached for use as the buria	dica		_	_ d								
	anding use at	n/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome						23d. Date	of deliver	v
e deat	the ette	Physician/Medica	in the past 12 1 ☐ Yes 2↓ 9 ☐ Unknown	ZNo	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnancy Other (specify)			Mon	th [	Day Year
that th	ed by detacl				ontributing to death b	ut not resu	Iting in the un	iderlying cause giv	en in Part I.	23e. Did to	obacco use contri	bute to the	cause of death?
quires	been sign should be	ed by	0+-	al Fi		TION				101	res 2□No	3 ☐ Proba	bly 4 Dunknown
law re	es been 2 should	Completed								24a. Was	an 24b. W	ere autop	sy findings available pletion of cause of
The	icate h									perfo 1 ☐ Yes	rmed // de	eath?	2□ No
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Itendi	death ctor: A	cati	2 Accident	investigation 6 ☐ Could not b	e One Place of Init	UDV - At hor	no form etro		Yes 2 □ No	29f Logation /6	Street and Numbe	- O - Our-t	See to March
a lor	s efter	Certification:	4  Homicide	determined	building, etc	. (Specify,	)	et, ractory, office		City or Tox	m, State)	r or nurar	Houle Number,
othe Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours efter death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier (Check only	Certifying Ph	ysician: T the hest niner: On the basis of	examinati	rladge, death on and/or inv	occurred at the tirestigation, in my a	ne, data and plans pinion, death occurr	and due to the e	Bausu(s) and man date and place a	ner as sta	teu.
o the	o the	Med	one) 29b. Signature and		and manner sta	ated.		29c. Licens			29d. Date signed		
-	>=0		Gun	Del	M.D.			RES	000	1	21241		
	10		7 6	171	completed cause of d	eath (Item	23a) (Type, F	Print)				647	***
	Sta	e	Dr. Sune 31. Date filed (Moni	th, Day, Year)	12 9000 32 Registra	1. 0:	and the same of th	n Squa	are Dri	ve, 10al	timore	, MI	121237
	Registr		Ñ	IAR 0 1 2		ars Signati	ure	W.					

Amend item#1, perMJ, 333,73,06 TI State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dorethea Ray Month **Physician** FEBRUARY 26 2006 /Medical 4b. City, Town, or Lucan.

H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Hours Min. May 07, 19 4c. County of Death . Facility Name (If not institution, give street and number Examiner SE 6012 150 tol 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F 216-36-4198 Yrs. Director NORTH CAROLINA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exeminer must be notified at 1 Yes 2 No Be Completed by Funeral Director MARYLAND 10g/Citizen of What Country? 10e. Street and Number 238 516 ATTERSON PARKAVENUE 120 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married ö Maryland 21215-0036 1 ☐ Yes 2X No 3 Widowed 4 Divorced BLACK netural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NURSE HOSPITAL YRS other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be f nent of Health and Mental I ant: If Itam 27 is marked o RANKLI 2 OROTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 E. LOMBARD ST. APT 102 (DAUGHTER) BALTO, MD, 21202 DOROTHY KAI Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2. Cremation 3 Removal from State Department o Important: if eny injury or 4 Donation 6 ☐ Other (Specify) BALTIHORE, MD. REMATORY 21. Signature of Funeral Service Licer(see 22. Name and Address of Facility FUNERAL HOME FULTON AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** atteasc Lerotic COROURRY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospitel or Attending Physician: The law requires thet the death certificate be executed burial-transit Due to (or as a consequence of): for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) o ate hes been signed by the page 2 should be detached 9☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ∏Yes 2 ∏No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No of Vital 1 ☐ Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient P 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) De Col Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12:0:1 7000 WUL Strice ) or leve Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Honth. **Physician** Ruchel 15 DM Kee 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Towny or Location of Death Examiner Baltimore A Medica TIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 M 2 □ F Director 217.20.5123 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits Itam 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic avant, the Michigan Examinar house be notified at Director 1 Pyes 2 No MD NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET 21229 4012 W. FRANKLIN USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7.5 h and Mental Hygiene.
7 te marked other then "no Elementary/Secondary (0-12) College (1-4or 5+) 9/14 GRADE LONG SHOREMAN SHIPPING NA 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) Be ADA GLOVER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 ia m any injury or other traum once. 4012 W. FRANKLIN ST. BAIL. NO Date 20c. Location (DAUGHTER) PAULA YOUNG 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 03.08.06 OWINGS MIUS, MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNDRAL SERVICE
5151 BAND. NATE PIKE, BAND. MO 21 21. Signiture of Funeral Service License Vanoh 23a. Part1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive disease **Physician** lung /Medical Due to (or as a consequence of): Examiner Renal failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner requires that the death certificate be executed ettending physicien and for use as the burial-transit /Uni cancel that initiated events resulting in death) Last Due to (or a consequence of): Physician/Medical use as the Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the e P.0. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed) 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funerel Director: After 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal Medic 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ION. Greene Street ba Rober 45 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg.:No.U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Februar 27,2000 12:43 PM **Physician** Louis Ross /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death Examiner altimore MI Yland n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2□ F Days Hours Min Yrs. 6-6-1919 217-05-5022 86 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits If item 27 is marked other then "naturel", or items 23e or 28e-f show or other traumatic event, the Medical Examiner must be notified at 1 DYes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Mount Royal Ave. # 603 1600 W. 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates 1 941 - 45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo African-American Specify: à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed UNK Butcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event anse. Joseph Weeden Annie Weeden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #603, Balto. 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Royal Ave Ella Mae Ross/ Wife 20c. Location - City or Town, State 20a. Method of Disposition 15☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 3-6-06 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vylie F/H PA of Balto. Co. 9200 Liberty Rd., Randallstown,MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or, as a consequence of) bulge Newosis/Cardiomyopathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine obstriction, States post lesection ed by the attending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Michael Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 410 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thipatient 1 Yes 2/D No 2 ER/Outpatient 3□ DOA this. 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death.
To the Funeral Director: After 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

Thomas

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

22. Registrar's Signature

29d. Date signed (Month, Day, Year)

27,2006

			State of Maryland / Department of Health and M		_ 4000	06072
	Physici	an	1- State Registrar Amend Item #8 Per FH C853 STEEPING OFF Peath  1. Decedent's Name (First, Middle, Last)	2. Date of Deat	Day Year	3. Time of Death
	/Medic Examin	al	FRANCIS W. RUZICKA  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	February	4c County of Deat	h . A
			Baltimore Washington Medical Center Glen Burne  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)   ff Under 1 Year   If Under 24 Hrs.	R Date of Birth	4me Ar	undel
ľ	Funeral Director		213-32-0319 18M 20F 70 Yrs. Months Days Hours Min.	Month, Day,	year) Mr	hplace (State or Foreign unity)
	yland		Usual Residence of Decedent  10a. State 10b. County 10c City, Town or Location	<del></del>		10d. Inside City Limits
	the Mar 28a-f s	ector	MD ANEARUNDEL TASADENA  10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	1 ☐ Yes 2 No
	23a or	ai Di	7684 Colonial Boach 20. 21122		0.5.	4.
<b>'</b> O	fter dez ritema dinar.m	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  12. Was Decedent of Hispanic Origin? (Specific Press, Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show he Medical Examinal must be notified at	þ	3 Widowed 4 Divorced Year or Dates:		Specify: W	hite
215	thin 72 e. en "nei	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of works)  Iffe. DO NOT use retired)	ng	16b. Kind of Business/	
d 21	be filed wintal Hygien of other the		17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, M	SONT PRIN Maiden Sumame)	ting office
Maryland	should be and Mental marked of umatic ev	To Be	FRANKLIN RUZICKA ROSEANN	AKINZ		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura  5TENE Z LONIS SON-IN-LAW  156LONG FONT CT PASSES			Tip Code)
Baltimore,	Pages 1 and of Hermint: If Item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
altin	permit. Par Depertment Important eny injury		4 □ Donation 5 □ Other (Specify)  21. Signature   Fun   Sprote License   22. Name and Address of Facility		tanover,	MD.
∞ ■	88 5 8		Daugherty Family Funeral Ho 2601 Mountain Road 23a Part Lenter the disease of complications that caused the death. Do not enter the mode of dving such as cardiac of	- Pasadena M	ID 21122	Approximate
	Physician		23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac os shock, or heart failure. Elst poly one cause on each line.  Immediate Cause (Final disease or condition  a.   Quite resulting in death)  a.			Interval Between Onset and Death
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oʻ	ate be executed thysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
8760,		dical	d			
Box 6	Attending Physicien: The law requires thet the deeth certific ir death. If death. ector: After this certificate has been signed by the attending pot the funeral director, page 2 should be detached for use as by the funeral director.	Physician/Me	IF FEMALE:  23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of del	,
о. Ш	thet the dee	ysici	in the past 12 months?  1  Yes 2 No 9 Unknown  1  Other (specify)		Month	Day Year
Division of Vital Records, P.O.	w requires thet s been signed t should be deta	by PI	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	
COLC	s been s should	Completed by	deep vein thrombo sis	24a. Was a		obably 4 Unknown topsy findings available
E Be	: The la	Com		autops perform 1 Yes 2	y prior to death?	completion of cause of
Z Z	ysicien s certifi director	To Be	25. Was case referred to medical examiner?  1   Yes 2   No   No   Other: 4   Nursing Hor	1	e) ince 6 🗆 Other (Spe	zifv)
o uc	ding Phin.		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. (njury at Work?		w injury occurred	
visio	r Attendi er death. rector: A by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Ru	ral Route Number,
ō	spital or A ours after seral Directificed in by		29a. Certifier  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a			stated
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	ate and place, and due	to the cause(s)
)	To with To	4	29b. Signature and title of certifier such 2 mp 29c. License number 0002246		9d. Date signed (Monti こんインムマン	
	5		30. Name and address of person who completed cause of death (tem 23a) (Type, Print)  Stuart Jacobs mp 3as Horpital D. Glen B.	n) vn [ 1	MD 210	41
	Sta		31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	UFICE	1119 010	0/
	Registr	ar	MAR 0 1 2006 Proces & South			

Registrar

29b. Signature and title of certifier

loupine

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

drill

OREI 111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature

**ORIGINAL** 

29c. License number

OCME

29d, Date signed (Month, Day, Year)

February 18. 2006

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Slav 109 Day 100

**Physician** /Medical Examiner **Funeral** 

1 - For State Registrer

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 le marked other then "natural", or iteme 23a or 28a-1 ehow emply injury or other traumette event, the Madical Examinat must be invitited at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examine Completed by Physician/Medical To Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

al	Jog Ce Juli 1-ch Februs	T U
er	4a. Facility Name (If not institution, give street and number) 5 40 0 dd 4b. City, Town, or Location of Death Nov thwest Hospital Court Road Randalls town  5 Social Security Number 5 Sax 7 Aga (In vrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8. Date of Birth	Baltmore
	5. Social Security Number  6. Sex 1 Months Days Hours Min.  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  8. Date of Birth (Month, Day) Usual Residence of Decedent	9. Birthplace (State or Foreign Country) 30  9. Birthplace (State or Foreign Country) Country)
ctor	10a. State MD Baltimore Baltimore	10d. Inside City Limits 1 Noves 2 □ No
al Dire	10e. Street and Number 2/2/5  10f. Zip Code 2/2/5	Og. Citizen of What Country? U.S. (Resident)
Be Completed by Funeral Director	11. Maritat Status  1  Never Married  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
etec	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
ошо	12 14 GOADE 24rs Private Duty Nurse	Nursing
BeC	17. Father's Name (First, Middle, Last)	Maiden Symame)
_o_	Marola Johnson Emel Ma	Cleothe
	19a. Informant's Name/Relationship (Type, Print)  Glen Shirley, Husband  6001 Park Heights Avenue	Batto, MD 21215
	20a Method of Disposition 20b. Place of Disposition (Name of Date	20c. Location - City or Town, State
	4 Donation 5 Other (Special) Lorraine Park 2/28/06	Baltimore, MD
	21. Ignatura of Funeral Service Licenses Service Licenses Service Licenses of Fability Processes 4161 Edmond Son Syenus	e Baltimor MD 21229
	23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr shock, or heart failure. List only one cause on each line.	Interval Between
	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerofic CardioV  Due to (or as a consequence of):  Due to (or as a consequence of):	ascular
	Due to (or as a consequence of):	-
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
ami	Cause (Disease or injury that initiated events c.  resulting in death) Last  Due to (or as a consequence of):	
E	Due to (or as a consequence of):	
dice	d	
hysician/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 prioriths? 1 □ Yes 2√□ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery Month Day Year
y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?
ed b	1   Y	es 2 No 3 Probably 4 Unknown
Completed by P	24a. Was a autops	
E 00	perfor 1 Ves	death? 2 No 1 Yes 2 No
Be	25. Was case referred to medical examiner?	
. To	1 Yes 2 No loss I I I Inpatient 2 ER/Outpatient 3 DOA of 4 Nursing Home 5 Residue 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe h	ence 6 Other (Specify) ow injury occurred
atior	27. Manner of Death 1	,
Medical Certification: To	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)
dical (	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the control of	
Me	29b. Signature and title of certifier 29c. License number 2	9d. Date signed (Month, Day, Year)
1	D 0036819 1	rebruary 63, 200x
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Lebruary 23, zook Lebruary 23, zook Al Randulth

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

**CRIGINAL** 

32. Registrar's Signature

CPM 06-01278 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Willie Stanford Amend unpend item#2,23a,27, pen/E, 8853,3/22/06 TT of Health and Mental Hygiene Amend item#23a,pen/E,8855,5/10/06 TT Cortificate of Death For A State Registrar 1-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20, 2006 Physician February 07:19 AM Willie Stanford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 11 27 50 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Washington, D.C. Days 1 M 2 F 55 Director 578-66-8709 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Exeminer must be notified at 1 TYPes 2 TNo Columbia Howard Director MD, 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 238 USA 6341 Golden Star 21044 P1. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 12 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 27 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 X No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced "natural", the Madical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Howard Univ. Hospital Patient Registrar permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 is marked other ti any Injury or other traumatic avent, IIIA 2006. 12 th. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mamie Lue Croskey ဂ္ <u>William Johnson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6341 Golden Star Pl. Columbia, MD. 21044 Amos Stanford, Jr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Feb. 28, 2006 Suitland, MD. Cedar Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licenses 23a. Parti/Entedthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line.

Immediate Cause (Final Appertune List only one cause on each line). 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine anding physicien and use as the burial-transit Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown s been signed by the should be detech Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Ves 2 \[ \] No 24a. Was an page 2 autopsy performed? certificate 2□ No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 27 ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Certification: To After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending s after death.

I Director: Aft
id in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò within 24 hours a
To the Funeral I
Completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE MIKE 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2006 -2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** ROBERT DAVID SCHOLAR February 24,2006 5:05 P<sup>M</sup> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOSEPH RICHEY HOSPICE HOUSE Baltimore City If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□ F Months Hours 45 Director 206-52-2850 Ohio Oct 3, 1960 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f shov other treumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/ABaltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3643 Roland Avenue 21211 LISA itеля 23a Completed by Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married ò 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 al Hygiene. Retail Restaurant Elementary/Secondary (0-12) Coflege (1-4or 5+) District Manager Corporation yrs and 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If tem 27 is marked eny injury or other treumatic ev 9088. Mary Alice 2 Scholar Rosa Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Township Drive, Uniontown, Pennsylvania 15401 Robin M. Scholar (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 2/27/2006 Baltimore, Maryland 21. Signatur of Funerer Serve Ligenskie

Martin D. Lawson 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approxim Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). use as the burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown s been signed is should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death, Be Completed by Probably 1 ☐ Yes 2 ☐ No 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 2 yes 2 2 No 24a Wasan 1 Yes 2 No medical 25. Was case referred to 26. Pface of Death (Check only one, examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification; To 1 Yes 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Man er of Death 28b. Time of 28d. Describe how injury occurred Hospitei or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours after To the Hospitel within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

State Registrar DHMH 17 Rev 1/2001 31. Date fifed (Month, Day,

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eted cause of death (Item 23a) (Type, Print

32. Registrar's Signature

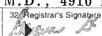
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	黄龙		1. Decedent's Name (First, Middle,	Last)							2. Date of	Death	D	V -	3. Time of Death
	ysicia Medic		Mary Skarulis								Febru	ary	18.	2006	2:50am N
	amin		4a. Facility Name (If not institution,	give stree	t and number,			4b. City	, Town, c	or Location of Death	h			y of Death	
			6904 River Road					Be	these	da			Mon	tgome	ru
	eral		5. Social Security Number 042-14-3595	S. Sex 1 ☐ M	21/10	ge (In yrs	s. last birthd Yrs	Months	Days	Hours Min.		Birth Day, Y	ear)	9. Birth	place (State or Foreig ntry) UANÍA
ъ.			Usual Residence of Decedent			1									
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Iteme 23e or 28e-1 show	fled at	tor	10a. State 10b. County  MD Mont	gome	t.u		City, Town or Bethes								10d. Inside City Limits 1X Yes 2 □ No
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h wit	4		6904 River Road						20812	7		1	USA		
ler deat	COST.TO	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. 4	Vas Decedent Armed Forces	?	U.S. 1			Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or to Rican, etc.)		14. Ra	ce - Ameri ick, White,	can Indian, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other then "natural", or	Evar	þ	3 Widowed 4 □ Divorced	1	f Yes, Give Year or Dates:	140		1 🗆 Yes	2X No	Specify:			Speci	ty: Whi	te
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VIB Ould Mer	natic	٩	Joseph Masialis							Armstus					
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e, P	hert		Monica S. Young 20a. Method of Disposition	– Vai	ighter	20h	4215	Yuma	St.,	NW, Was	hingto				- Chan
	or ot		1 🕅 Burial 2 □ Cremation		val from State	' 1	Place of Di cemetery,					20	c. Location	- City or 1	own, State
LIM Pa tmen tent:	jury		4 ☐ Donation 5 ☐ Other (Sp			Mt	. Eri				5/06	На	ure d	le Gro	ice, MD
Baltimore, Dennit. Pages 1 ar Department of Hea	DC S		21. Signature of Funeral Service L	censee		_	. 1	Mitche Mitche	and Addre	ss of Facility Smith Fun hingion,	eral H	ome.	P.A.		
u au :	e 0	- 4	Zaramer"	٠. ح	the same	4 0	,	123 S.	Was	hington,	Havre	de '	Grace	, MD	21078
			3a. Part1. Enter the disease, or of shock, or heart failure. List of	omplicationly one ca	ons that cause ause on each l	d the de ine.	ath. Do not	enter the mo	de of dyli	ng, such as cardiad	or respirator	y arrest	•		Approximate Interval Between Onset and Death
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/Med Exam			resulting in death)		Due to (or as										o years
Exam	iner		Sequentially list conditions	b											
/ 0	iii	De	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	Due to (or as	a conse	equence of):								
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Box auth cer	or us	an/	23b. Was decedent pregnant in the past 12 menths?		f yes, outcome 1 □Live birth	2 ☐ Fe	tal death	3 ∏Ectopic <sub>I</sub>	pregnanc	y			1	ate of deliv	ery Day Year
he de	) per	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4∏Pregnant a 9□ Unknown	t time of	death	5 Other (s	specify)			-	141	Ontil	Day Teal
P. P.	detached	Physician/Med		a	. Al A A Ab- 1						00. 0	124.4.4			
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Division of 1 or Attending Physatter death. Director: After this	the funeral director, page	ation	27. Manner of Death  1 Natural 5 Pending investige	ition	8a. Date of Inj (Month, Da	ıry ıy Year)	28b. Tim Inju	y M	28c. Injui Wo 1 [	ryat rk?  Yes 2 □ No	28d. Descri	be how	inju <b>ry</b> occu	rred	
= = 0	>	Sertific	3 Suicide 6 Could n 4 Homicide determine		8e. Place of In building, e	tc. (Spec	home, farm, cify)	street, facto	ry, office			n (Stree Town, S		ber or Rur	al Route Number,
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State

Registrar

Helene C. Freeman, 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Helene (Freeman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 4910 Mass. Ave., NW, Suite 212, Wash. DC 20016

29c. License number

D0042783

29d. Date signed (Month, Day, Year)

February 20, 2006

				1 - For State Registrar	State o	f Marylar		artment of I	Health and N	fental Hy	giene	) 6	06078
		Physicia		1. Decedent's Name (First, Middle, I		-				2. Date of Di Month Februa	eath ary 28 :	20ŎĠſ	3. Time of Death 8:30 A M
		/Medic Examin		Verla H. Spe		mber)		4b. City, Town, o	or Location of Death			nty of Death	
	100		S#	Paradise Assiste	ed Living	<u> </u>		Cator	sville		Ва	ltimo	re
	3-2	Funeral Director		5. Social Security Number 6 218-18-3490	.Sex 1 □ M 2 🔀 F	7. Age (In yrs. 82		If Under 1 Year Months Days		8. Date of Bi (Month, Di July 24	rth ay, Year)		place (State or Foreign ntry) yland
				Usual Residence of Decedent						July 25	1923	mai	ylanu
		arylar ahow dat	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
		Ba-f a	cto	Maryland Baltin	nore		Catons						1 ☐ Yes 2 ☑ No
		with the	Dir	10e. Street and Number	. 1			10f. Zip Code			10g. Citizen o	of What Cou	intry?
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	Σ	D = D =		Charles Spence	Son		407 I	Harwood R	load; Cato	nsville	e, MD 2	1228	
	ore	of He of He fitem r oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3	□ Pamoval from	20b. F	Place of Disponentery, cre-	osition (Name of matory or other pla	ce)	Date	20c. Location	n - City or T	own, State
	Ĕ	Pages ment of l ant: If it		4 Donation 5 Other (Spe		Me		ematory		2006			, Maryland
	Ball	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Lic	cen ee	111	2:	2. Name and Addre Funeral	ess of Facility Ste Home of Condson Ave	rling / atonsy	ille, Į	Schwal	Witzke
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	, P.O.	res that the igned by be detacted	y Ph	Part II. Other significant conditions	s contributing to d	eath but not res	sulting in the u	inderlying cause gr	ven in Part I.	23e. Did	tobacco use co	intribute to t	the cause of death?
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	ital	ysician: The is certificate hi director, page	BeC	25. Was case referred to medical					26. Place of Dear			10 103	200
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		10		30 Name and address of person w	o completed caus	se of death (Iter	n 23a) (Type,		- 4		11-	1-0	<i>j</i>
		Ψ		Katrock W.W	With.	0, 40	15 Fr	derick	Rd, #	202, C	saltim	one, t	2, 2006 10 21278
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Sennese 1:10 February 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** E-lizaheth move Wrsina Center Sal If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min Hours 1 ☐ M 2 🖾 F 216-42-4365 88 Director 1917 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner count by coliffied at 1 Yes ZNO Howard Director Maryland Elkridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5887 N. Bonnie View Lane Funeral 21075 United\_States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Heatth and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles G. Sandmann Anna E. Cooch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Astrid J. Oldham, Daughter 1914 Aquinas Dr., Gambrils, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State St. John Cemetery Mar. 3,2006 Columbia, Maryland <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facilia Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 21. Signatur ner Servic Licensee any ir M01290 1630 Edmondson Ave., Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician emen ears /Medical Due to (or as a consequence of): Examiner minth OVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the t attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ melli 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 21**X**No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Director: After 5 Pending investigation 1 Natural 1 Yes 2 1 No Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mina 3 0 ) enson

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

2006

			For State Registrar	State of	Maryland		artment of H tificate of i			iene	0.5	080
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	/Medic Examin		4a. Facility Name (If not institution,					Location of Death	1	4c. County of		1
	Francis		Howard County G		ospital 7. Age (In yrs. Ia	st birthday)	If Under 1 Year	ımbia   If Under 24 Hrs.	8. Date of Birth	Howar	9. Birthplace (S	State or Foreign
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Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		* 4 □Donation 5 □ Other (Special Service Li		riet	22	Name and Addre	ss of Facility				
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	thin 2, tha F mplete	Medi	one)  29b. Signature and title of certifier	and manr	ner stated.		29c. Licens			29d. Date signed		
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	10		30. Name and address of person w	no completed caus	e of death (Item	23a) (Type,		10	wy Ca	lumbia	40 2	1044
	Sta		31. Date filod (Month, Day, Year)	L.	gistrar's Signat	ure	Park B	(	1	1019		
	Regist	rar	MAR 0	2005	Collisses A	Jo Sa	THE WAY					

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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examination to notified at once.	To Be Completed by Funeral Director	Md.
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dent's Name (First, Middle, Last) 3. Time of Death 1:05p M 4c. County of Death 4b. City, Town, or Location of Death lity Name (If not institution, give street and number) 38 N. HOWARD ST, BALTO 21218 BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Security Number 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Hours 1□M 2**X**F 0-24-3411 86 2-18-20 S.C. esidence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits Baltimore 1 Yes 2 No NA eet and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 38 Howard Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) entary/Secondary (0-12) College (1-4or 5+) Other Peoples Homes Domestic grade er's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hutchinson Julia Evans Elijah ormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Montpelier Street, Baltimore, Md. Daughter ia Jenning 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State thod of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Owings Mills, Md. Garrison Forest Vet. 3-3-06 nature of Funeral Service Licens Baltimore, Md. 21202 22. Name and Address of Facility 1101 E. North Ave. March F.H. East Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. ate Cause (Final DAYS J27514 or condition g in death) Due to or as a consequence of): **Examiner** Vecubitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit hemiplegin The law requires that the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Condiovasculon 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ¥No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification:

fo the Hospital or Attending Physician: Director: After the within 24 hours aft To the Funeral Di completely filled in

1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D 00 31295 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCK RAVEN Blod, P.O.B WENDY KLOESZ

Ste 208A, BALTE MO

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 0

32. Registrar's Signature 2006

06 - 1440Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f, perMF, e853,3/8/06 TT State of Maryland Department of Health and Mental Hygiene B.K.S UNK. Ronald Stevenson State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year stevenson 1:24 P M FEB 26, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY JOHNS HOPKINS HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
 Aountry) **Funeral** Days Hours 219-78-323 Usual Residence of Decedent 1 X M 2 ☐ F Yrs. Director with the Maryland 10a, State 10b. Count 10c. City. Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Medical Examiner must be notified a 1 XYes 2 No Completed by Funeral Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 or iteme 23a deeth 01 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If Item 27 Ie marked other then "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) er 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be stevenson onal ပ 19a. Informant's Name/Relationship (Type, Print) (grandmother, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .Md. 21216 alto 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Himportant: If Ite eny Injury or ot once. 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) emeter 21. Sign wire of Funeral Service License 22 Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Narcotic (heroin) and alcohol intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 □ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: Certification: To Yes 2□ No 1 Inpatient 2 X ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Pis 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐No within 24 hours after death. To the Funeral Director: A 2 Accident investigation /26/06 unk the 6 X Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1210 N. Eden St. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled Baltimore, MD house 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Check only Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) FEB. 27, 2006 29b. Signatu e and title of certific O.C.M.E me and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar 2006 MAR 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a, PIT 27, penME 6833.3/2/05 IT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** LEE VAN SINGLETON 18:10 Feb 7, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner BON SECOUR HOSPITAL BALTIMORE** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 🗆 🗶 1 2 🗆 F Yrs Director 218-78-4656 45 Aug 18, 1960 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 OXFORD COURT 21201 U.S.A death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**90 Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **CLEANING** WAREHOUSEMAN permit. Peges 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic event space. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE SINGLETON SUSAN E. CONYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LIZZIE SCOTT AUNT 2703 PELHAM AVE. BALTIMORE, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State □ Stremation 3 □ Removal from State 5 □ Other (Specify) 1 Buriak 2 TK remation **BAYVIEW CREMATORY** 02/20/06 BALTIMORE, MD 4 Dogation 21. Signa 22. Name and Address of Facility MILLER'S METROPOLITAN CHAPEL 1639 N. BROARDWAY BALTIMORE, MARYLAND 23a. Part1 En e the dis se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit death certificate be executed and Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. ettending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the th detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Acquired Immunodeficiency Syndrome (AIDS) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy rmed? 200 No certificate 1 Yes 1 Yes or Attending Physicien: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation s efter death. t ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours of To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pean street, Baltimore, MD 21201 ZABIUCLAH 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State MAR 0

DHMH 17 Rev 1/2001

Registrar

2006

			1- For State of Maryland / Department of Health and Months and Mon	ental Hygier	ZIIIIA HANR	and the second
I	Physicia		1. Decedent's Name (First, Middle, Last)  James 5chaefer	2. Date of Death Month	2 Year 0628	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Center 4b. City, Town, or Location of Death Story & Randals town		Baltmove	
	Funeral Director		1⊠M 2□ F Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Mar 17, 19		reign
	aryland •how	J.	10a. State 10b. County 10c. City, Town or Location		10d. fnside City Lit	
	the N	Director	MD Baltimore Reisterstown  10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Country?	
	h with	ai D	110 Hammershire Road 21136	U	.S.A.	
920	within 72 hours after death with the Maryland jiene. r then "natural", or Items 23a or 28a-f ehow Ite Medical Exacular must be notified at	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 56-58		14. Race - American Indian, Black, White, etc.  Specify:  White	
21215-0036	within 72 ho lene. then *natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Coflege (1-4or 5+)  7  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Salesman	ng	Kind of Business/Industry	
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Maryland	should be ind Mental marked c	To Be	Frank N. Schaefer, Sr.	Jeanette	Hare	
Man	and rand		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural			
Baltimore, I	Pages 1 and 2 should be filed field of Health and Mental Hyg nt: If Itam 27 le marked otherry or other treumatic event,		Sue Schaefer Wife  20a. Method of Disposition 1 Burial 2 The Commentation 3 Removal from State 4 Donation 5 Other (Specify)  10 Hammershire Read 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Ser 3/1/6	ate 20c.	stown Maryland 21 Location - City or Town, State	<u>.136</u>
Balti	permit. Pages 1 Department of H Important: If Ita any injury or ot once.			11824 Rei Reisters	sterstown Road town, MD 21136	
8760,	death certificate be executed  Medical Examination and physician and process as the burial-transit	cal Examiner	shock, or heart failure. List only one cause on each line.  frimediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, based to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  Due to (or as a consequence of):	vascula	News Interval Betweer	1
.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day Year	
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al Reco	The la ate has page 2	Completed		24a. Was an autopsy performed 1 Yes 2 2	24b. Were autopsy findings avail- prior to completion of cause death? 1 \( \text{Yes} \) 2 \( \text{No} \)	able of
Zit	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1  Yes 2 No  Cher: 4 Nursing Hom		- Tau	
0 ر	g Physier this	n; To	27. Manner of Death 28a. Date of figury 28b. Time of 28c. Injury at 2	8d. Describe how in	6 ☐Other (Specify) jury occurred	
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	the Hospital hin 24 hours a the Funeral I npletely filled	Medicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the cause ad at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)	
	To the within 2 To the Complet	Me	29b. Signature and title of certifier 29c. License number D 0036 81		Date signed (Month, Day, Year)  Livuary 25, 20	006
	541			nelton,	bruary 25, 20 Candallstonna	ny
Ł	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 1 2006			

ANGELA LYNN SELLMAN Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNpend item# 23a-b,PII\_27,28a-f,\_penME, 6854, 4/12/06 TT. 06-01432 unpend item# 23a-b,PII 27,28a-f, perME, C854, 4/12/06 TT

Amend item#27,28d,perME,8850,6/14/06 epartment of Health and Mental Hygiene () () 6 RJ06085 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year February 26, ANGELA LYNN SELLMAN 2006 12:17 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 907 North Fulton Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🖾 F Yrs Director 216-62-4842 47 3-28-1958 MARYLÁND Usual Residence of Decedent Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow a codiffied at ahow MD. N/A BALTIMORE Directo 1 TXYes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ rai', or itama 23a or Examiner must be 907 N. FULTON AVE. 21217 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1

Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced naturai Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) BETTER BUSINESS other than College (1-4or 5+) -12-INFORMATION SPECIALIST BUREAU of Heelth and Mental Hygis fitam 27 is marked other r other traumatic svent, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Heelth and Mental I LAWRENCE R. SELLMAN VIVIAN SPRIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 N. FULTON AVE. BALTIMORE, MARYLAND 21217 VIVIAN SELLMAN (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispositio Date 20c. Location - City or Town, State Depertment of important: if it any injury or o 1 ☐Burial 2 ☐ C emation ☐Removal from State 4 Donation Other (Specify) KING MEMORIAL PARK 3-2-2006 BALTIMORE, MARYLAND 21. Signature censee JONATHAN HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac arrhythmia resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac hypertrophy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by should b Seizure disorder 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an rector, page 2 s autopsy /performed? Yes 2□No Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) At scene ို 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury Unk (Month, Day Year) 28b. Time of Unk 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural ınknown rector: A <del>subject fell while climbing ropes</del> 1 ☐ Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 | Homicide ŏ school unk within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29s Cortfia the 29b. Signature and title/of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME February 26, 2006 of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's S

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37. Registrar's Signature

THOMAS within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

UNKNOWN UNKNOWN Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  $M \cdot D$ P18616 FEB 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON AVE, BALTIMORE - 21229, MARYLAND PRIYANKA NELLOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature make **ORIGINAL** 

Registrar

29a. Certifier

(Check only

Medicai

			1 - For State Registrar	State of Marylan		artment o			Re	g. No.	16	06087
	Physicia	an	1. Decedent's Name (First, Middle, Last)  JAMES TYSO	N TILDON					Date of Deat		008	3. Time of Death 03:30 A M
×	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tow	m, or Location of	of Death		4c. County	of Death	ח
			GREATER BALTIMORI			TOWSO		24 Hrs o	Data of Birth	BALTI		
	Funeral Director		210 20 200	7. Age (In yrs. 74	Yrs.	Months Da			Date of Birth (Month, Day, Igust 7, 1	931	Mar	nplace (State or Foreign yland
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	with the	Dire	10e. Street and Number 209 Churchwardens R	road		10f. Zip Cod 21212	de		10	og. Citizen of V USA	Vhat Co	untry?
36	be filed within 72 hours after death with the Maryland at Hygiene. A letter at 14 years of the Wedleal Exameration must be exhibited at event, the Medleal Exameration must be exhibited at	by Funeral Directo		12. Was Decedent Ever in U Armed Forese? 1 Yes, ZYZNo If Yes, Give Year or Dates:			of Hispanic Ori Cuban, Mexican No Specify:		fy Yes or No- can, etc.)	14. Rac Blac	e - Amer ck, White v: Bl	•
21215-003	within 72 hourne. ne. han "natural	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	1	dent's Usual Od kind of work do DO NOT use re	ecupation one during mos atired)	t of working		Univer		industry
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Maryland		To B	Charles Garfield Ti						Elizabe			
	12   12   18   18		19a. Informant's Name/Relationship (Typ Sania Amr	оө, Print) Wife	19b. Maili 209 (	ng Address <i>(Sti</i> Churchwa	ardens	Road I	Baltimo	re, Mai	State, Z Cyla	nd 21212
Baltimore,	Pages 1 a nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Re	omoval from State	cemetery, crei	osition (Name o matory or other of Ceme	place)	3/1/0		20c. Location		Town, State Maryland
altim	permit. Pages 1 and Department of Healtl Important: If Item 21 any injury or other t		4 ☐ Donation 5 ☐ Other (Specify)  21 Sunature of Funeral Service License									l Home Inc
m m	99 1 1 9		Nennis & Iphe	Make	Do 201 201	100 100 000 00					Mary]	land 21212 Approximate
Y	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	* 1	*		dying, such as	cardiac or i	espiratory arre	331,		Interval Between Onset and Death
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8760, 🛠	rate be executed obysicien and the burial-transit	ical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	July	cance	~				Sym
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P.O. Box	Attending Physician: The law requires that the death certificate be executed refeath. refeath. ector: Atter this certificate has been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	⊒Ectopic pregn: ⊒ Other <i>(specif</i> )			200		te of deli inth	ivery Day Year
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions con	atributing to death but not res	sulting in the u	inderlying cause	e given in Part I		23e. Did tob	_/		the cause of death?
Division of Vital Records,	The law re cate has bee page 2 sho	Completed					-		24a. Was all autops perform	y ned?/	prior to d death?	topsy findings available completion of cause of
Vita	ician: certific	Be	25. Was case referred to medical examiner?	lospital:			Othor		Check only on			
on of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ition: To	1  Yes 2 No	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c.	1 ☐ Yes 2 ☐	28	d. Describe ho			cify)
Divisi	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Ath building, etc. (Speci		reet, factory, off	fice	28	f. Location (St. City or Town	reet and Numb , State)	er or Ru	ral Route Number,
	Hospital 24 hours a Funeral etely filled	Medical C		sician: To the best of my knowner: On the basis of examinating and manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier				cense number			9d. Date signe	d (Monti	h, Day, Year)
	``		- Fillen			<u> </u>	) 634	22		02/2	8/0	6
	30		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print) Street	Balt	imme	2120	14		
	Sta		31. Date filed (Month, Day, Year)	mpleted cause of death (Ite 6-701, N.C.) 32 Registrar's Sign	ature	anties	1 7					
	Regist	al	MAR 0 1 200	JO BERGERS A	-							

			1 - For State Registrar	State of Ma	ıryland		artment tificate				1	Reg. No.	6	3608	38
	Physici /Medic	al	1. Decedent's Name (First, Middle, Las Stavros K. Touts:	Ĺ			4. 0.		Leekee		2. Date of De Month Februa	ary 25,		3. Time of 1	Death M
	Examin	e ei	4a. Facility Name (If not institution, give Upper Chesapeake 5. Social Security Number 6. S	Medical Co		ast birthday)		1 Ai	Location o  r  If Under 2  Hours		8. Date of Bird (Month, Da Jan. 5	Harfo	9. Birthp	lace (State or	Foreign
	Director		234-46-7798  Usual Residence of Decedent  10a. State  10b. County	<sup>™</sup> <sup>2</sup> F 80		Yrs.					Jan. 5	, 1920	Gree	CÉ Od. Inside Cit	y Limits
	r 28a-f sho	Director	Md. Harford  10e. Street and Number				Falls					10g. Citizen of V	Vhat Coun	1 ☐ Yes	2√No
36	permi, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any ritury or other traumatic event, the Medical Examinat rulest be multiful at ADE.	Funeral	1104 Grist Court  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:			Was Deced f Yes, spec			gin? (Spei i, Puerto F	cify Yes or No Rican, etc.)	U.S.  14. Rac Blac  Specify	e - Americ		
Maryland 21215-0036	d within 72 hou giene. er than "natura , the Medical E	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 8 years	ducation de completed) College (1-4or 5-	+)	(Give life.	dent's Usua kind of wor DO NOT us pente	k done d e retired,	uring most			16b. Kind of Bu	carp	,	
yland	iould be file Mental Hy varkad othe natic event	To Be C	17. Father's Name (First, Middle, Last)  Kosmas Toutsi			105 14-11		(64	I	rene	Angel:	, Maiden Sumarr a Kourel er, City or Town,	i	Codel	
ıore, Maı	iges 1 and 2 st of Health and : if item 27 is n or other traun		19a. Informant's Name/Relationship ( Irene Eliou/daug) 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □	hter			Gris	t Co	urt,	Fall	ston, l	MD 21047 20c. Location - Baltimo	City or To	wn, State	
Baltimore,	permit Pa Departmen Important any injury		4 Donation 5 Other (Specification of Funeral Service Licer	1500	,	22	2. Name and Schim	d Addres unek	s of Facilit	eral	Home o	f Bel Ai	r, I	nc.	
68760,	Physician and // Medical Examiner site phrain-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Securities list non-littorn if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Support to the control of the con	S a consequ M O a consequ	rence of):	er the mode	e of aying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betwo	veen
.O. Box 6	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3[	⊒Ectopic pr ⊒ Other (sp						te of delive	*	/ear
а.	w requires that been signed by should be deta	b	Part II. Other significant conditions of RENAL FAIL	MSE				ause give	en in Part I.		23e. Did t	obacco use cont Yes 2□No	ribute to th	/	eath? Inknown
al Reco		Completed	URINARY T	RACT IN	1FE	C770					24a. Was auto perfo 1 Yes	psy ormed?/	Were auto prior to co- death? 1 \(\sum \text{Yes}\)	psy findings a mpletion of ca 2 No	available ause of
Division of Vital Records,	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	Hospital: 1 Inpatie  28a. Date of Injui (Month, Day	ry	ER/Outpatie 28b. Time o Injury		8c. Injury Work	er: 4 🗆 Nu	rsing Hor		onel dence 6 🗆 Oth how injury occur		y)	
Divis	tai or Attencrs after death al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At ho	me, farm, st	reet, factory	, office		2	28f. Location ( City or To	Street and Numb wn, State)	er or Rura	il Route Numi	ber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical		nysician: To the best of niner: On the basis of and manner sta	examinat		vestigation	, in my o	pinion, dea	ith occurre	ed at the time,	date and place,	and due to	the cause(s)	
)	/		30. Name and address of person who	luyaruka completed cause of d	eath (Item	23a) (Type,	Print)	D	25	02	7	FEBRUA	RY	26,2	.006
	St. Regist	ate		BHYANKA 6. Registra	ar's Signa	LI ture	VORT	HI	4 VEI	vue	BE	LAIR	MD	910	14

DHMH 17 Rev 1/2001

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2-25-06

Teutsis Stavilos

Division of Vital Records. P.O. Box 68760. CHARLOTTE WEGLEIN

4	Stete Registrar  I. Decedent's Name (First, Middle, Las  CHAR LOTT  I. Decedent's Name (If not institution, give  STELLA MAR'S  S. Social Security Number  6. Se  Just 19-44-8960  Just 19-44-896	street and number)  HOSPICE	(WE G-L yrs. last birthday)	4b. City, Town,		2. Date of Dea	Reg. No.  ath  Day  Yea  26 2006	
5	A. Facility Name (If not institution, give 570 (If A MAR S. Social Security Number 6. Social Security Number 118-44-8960 11 Jual Residence of Decedent 10a. State 10b. County	street and number)  HOSPICE  X J7. Age (In)	yrs. last birthday)	4b. City, Town,	or Location of Death	Month	Day Yea	
5 3 1	Social Security Number  6. Social Security Number  6. Social Security Number  6. Social Security Number  7. 18 - 44 - 8960  1. 10a. State  10b. County	street and number)  HOSPICE  X J 7. Age (In	yrs. last birthday)	4b. City, Town,	or Location of Death	TED 1	V 60 MUUL	
13 1	5. Social Security Number 6. Sec. Social Security Number 6. Sec. Sec. Sec. Sec. Sec. Sec. Sec. Sec	HOSPICE IX J. Age (In)		*			4c. County of D	
10	5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In		/ / / /	IDNIUM		BALT	
10	318-44-8960 1 Jsual Residence of Decedent 10a. State 10b. County	M 22 F		If Under 1 Year		8. Date of Birt		Birthplace (State or Fore
-	10a. State 10b. County		2 × 113.	Months Days		Dec 11	1943	Country) MS
-	MU BALI	•	. City, Town or Lo	PARKULLE	,			10d. Inside City Lim
		IMORE						
	10e. Street and Number	S Ave		10f. Zip Code	1200		10g. Citizen of What	
2  -	2701 EMERAL				1734			
	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc.
	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1□Yes 2□No	Specify:		Specify: }	white
	3 Widowed 4 Divorced	Year or Dates:						,0 , , , ,
3	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occi	e during most of wor	king	16b. Kind of Busine	ss/industry
-	Elementary/Secondary (0-12)	College (1-4or 5+)		_	•		HOGAT	
5		NIA		DECLET		(5) 14)-141-		, ,
3						_		
	Kenneth Mei	er sr						
	19a. Informant's Name/Relationship (7	ype, Print)		_		_		
	STEVEN WEGL	ein	2701	1 EMERA	LD AVE TO	Alto. M		
			<ol> <li>Place of Dispo cemetery, crer</li> </ol>	osition (Name of matory or other pi	ace)	Date		
1		Removal from State		_	ce 3 /3	106	Balto M	5-
					ress of Facility	100 1400	~ DA	
Ţ	6 11 1 1.	Stopps	1	AUL STA	ella Fung	Da John MA	21234	
+		plications that caused the						Approximate
2	Cause (Disease or injury that initiated events	b. Due to (or as a cor	nsequence of):					
	23b. Was decedent pregnant			Fetonic pregnan	icv			,
33151	in the past 12 months? 1 □ Yes 2 🎇 No 9 □ Unknown					77225 A	Month	Day Year
	Part II. Other significant conditions c	ontributing to death but no	t resulting in the u	inderlying cause o	jiven in Part I.	23e. Did t	obacco use contribut	e to the cause of death
						10	Yes 2 □ No 3 □	Probably 4XIUnkn
						240 1000	24b Word	autopsy findings avail
1						autor	osv prior	to completion of cause
5								res 2□ No
2				T.				
2	1 ☐ Yes 2 🗶 No	1 🗀 Inpatient						Specify) HOSPIC
	12.00	28a. Dale of Injury (Month, Day Yea	ar) 28b. Time o	of 28c. In	ury at ork?	28d. Describe	how injury occurred	
5	2 Accident investigation	1		M 1	Yes 2 No			
	datarminad	288. Place of Injuly		reet, factory, offic	9	281 Location (S City or Tox	Street and Number o. vn, State)	r Rural Route Number,
5								
2				29c. Lice	nse number		29d. Date signed (M	onth, Day, Year)
				T	110000	_	7/70	106
	- 6				143125		4/ 4/	100
	30. Name and address of person who				m	MD 010	0.2	
				LEY RD.	TIMONIUM	, MD 210	<b>7</b> 3	
		17. Father's Name (First, Middle, Last)  Kenneth Mey  19a. Informant's Name/Relationship (7)  Teven We G-L  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature of Funeral Service Licenth Council C	17. Father's Name (First, Middle, Last)    Remorth   Meyer   Sk	17. Father's Name (First, Middle, Last)   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing   20c. Method of Disposition   2 Teven   2 Cremation   3   Removal from State   20b. Place of Disposition   2 Teven   2 Cremation   3   Removal from State   2 Cremation   5   Other (Specify)   21. Signature of Funeral Service Licensee   2 Cremation   5   Other (Specify)   21. Signature of Funeral Service Licensee   2 Cremation   5   Other (Specify)   21. Signature of Funeral Service Licensee   2 Cremation   5   Other (Specify)   22. Signature in the load talure. List only one cause on each line.   2 Cremation   2 Crema	17. Father's Name (First, Middle, Last)   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street)   20a. Method of Disposition   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of camelery, crematory or other picture)   20b. Place of Disposition (Name of Camelery, crematory or other picture)   20b. Place of Disposition (Name of Camelery, crematory or other picture)   20b. Place of Disposition (Name of Camelery, crematory or other picture)   20b. Place of Disposition (Name of Camelery, crematory or other picture)   20b. Place of Disposition (Name of Camelery, crematory or other picture)   20b. Place of Disposition (Name of Camelery, crematory or other picture)   20b. Place of Disposition (Name of Camelery, crematory or other picture)   20b. Place of D	Sequentially list conditions (arm least)   Sequentially list condi	19. Mailing Address (Street and Number or Rural Route Number of	19. Informatic Name (Prist, Modes, Last)   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number. City or Town. Stat   19. Mailing Address (Street and Number or Rural Route Number or Rural Route Number. City or Town. State   19. Mailing Address (Street and Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural

State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 🔓 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 4:37PM Louise Woodall Mary 26 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore NA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☑ F 218-22-1376 Director Yrs. 7-16-25 80 Md. Usual Residence of Decedent the Maryland 10b. Count 10a State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f ehor the Medical Examinar must be notified at Md. NA Baltimore X□Yes 2□No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 E. 25th St. 21218 USA Apt. 3-J Completed by Funeral death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Peges 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No 3 ₩ Widowed 4 Divorced Specify: Black "nature!" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4 or 5+) 8th grade Varies Nursing Asst. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Stevens Myrtle Gibbs ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health i Moses Wilson 317 E. North Ave. Apt. 311, Baltimore, Md. 21202 Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State jo # 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Decation 5 ☐ Other (Specify) 5 criment criant: ff injury o King Mem. Pk. 3-4-06 Randallstown, Md. permit.
Departn
Imports
any nju 21. Sign turn of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseas) or condition resulting in death) Obstructive Pilmonary Priysician 30 years /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Due # Examiner burial-transit The law requires that the death certificate be executed end P.O. Box 68760, 1 Due to (or as a consequence of): physicien Physician/Medical the t as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 □ No 3 Probably 4 □Unknown been si 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificete has birector, page 2 s 1 Yes 1 ☐ Yes 2 ☐ No of Vital 2 No or Attending Physician: ours after death.

lerei Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerei I
completely filled To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial M.D. NOUYE M 1144 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1,perM1,6852,3/1/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mavis Dudley Williams 3. Time of Death Month Day 20, 2006 Physician 5:40 AM · LLI AMS /Medical 4c. County of Death Facility Name (If not institution give street and number) Gity, Town, or Location of Death Examiner atonsville 14mme ommons 7. Age (In yrs, last birthday) Year If Under Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 □ M 2 1 F 214-20-409 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location in then "naturel", or Items 23a or 28a-f ehow the Medical Exercit without be notified at 1 Yes 2 No by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Nuraber 2/117 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after o Health and Mental Hygiene. Ism 27 Is marked other then "naturel", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) hnician nouse Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Sumame Be Bessie Durre 2 19b. Mailing Address (Street and Number or Rural Route Number important; if itsm 2? lle 20a. Method of Disposition

1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) 20b. Place of Disposition Date City or Town, State 20c. Location 3 Removal from State 21. Signature of Fundal Service Lice VICES ore Natl. P. Ke. MD 21229 Balto. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Interval Between Onset and Death Park Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 Donknown 1 Tes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? After this certificate 2 No 1 Yes 2 No 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director; 6 Could not be 3 🖺 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 9 Hend 29c. License number Mo 3694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JURAKHIA Rd 1009 frederick MD 32. Signature 31. Date filed (Month, Day, Year)
MAR 0 1 2006 State Registrar

L 24	.0		1 - For State Registrar	State of Maryland	d / Department Certificate			iene 0 0 6	06092
	Physici		Decedent's Name (First, Middle, Last)	00 1/11:	amson		2. Date of Death Month FEBRUAR	h Dav Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s			own, or Location of Deat		4c. County of Deatl	
			1906 EDMONDSON AVE			IMORE		NA	
	Funeral Director		770-10-2007	7. Age (In yrs. la	Ast birthday) If Under 1 Yrs. Months I	Year If Under 24 Hrs Days Hours Min.		1946 We	hplace (State or Foreign unity) ST Virginia
	yland III		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location		,		10d. Inside City Limits
	a-f sh	ctor	Md nls	- Bo	altimore				1 Stes 2 No
	ith the	Dire	10e. Street and Number	,	10f. Zip C	code	10	0g. Citizen of What Co	untry?
	eath v	Funeral Director	1906 Edmond 11. Marital Status	12. Was Decedent Ever in U.S	S 13 Was Deceder	ot of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame	rican Indian
980	72 hours after death with the Maryland Instural, or Iteme 23a or 28a-1 show dical Endrinal must be rediiled at	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 □ Yes 2 to No If Yes, Give Year or Dates:	If Yes, specify	nt of Hispanic Origin? (Sy Cuban, Mexican, Puer No Specify:	to Rican, etc.)	Black, White	
215-0036	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation a completed)	16a. Decedent's Usual (Give kind of work	done during most of wo	rking	16b. Kind of Business/	industry
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	retired)		600001	Construction
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	ਦੂ <u>ਦ</u> ਛ		27. Manner of Death	28a. Date of Injury Found (Month, Day Year)		c. Injury at Work?	28d. Describe ho	w injury occurred	+0
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			30 Name and address of person who co	impleted cause of death (Item	ZJa) (Type, Print)	11 Penn S	reet B	Altimore M	1ACYLANDODO
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DHMH 17 Rev 1/2001

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laryland ehow	_	10a. State 10b. County		10c. City, Town	or Location		_			10d. Inside City Limits		
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19		Dr. DRIOURS IS COL		, Fra	n Klin Sq	uare Dr	ive, Ba	Himor	e, Mi	)21237		
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** FRANCIS ATKINS JR. WILLIAM FEBRUARY 12 2006 6:13 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 6934 HAWTHORNE STREET LANDOVER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month), Day, Year) | APRIL 22 1957 | WASHINGTON, DC 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Yrs. Director 578-78-5466 48 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Yos 2 □ No LANDOVER PRINCE GEORGE'S Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "netural", or Iteme 23a or the Medical Examiner must be r 20785 U.S.A. 6934 HAWTHORNE STREET Pages 1 and 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th SPECIAL POLICE OFFICER and Mental Hygirs marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM F. ATKINS SR. JUANITA DYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 6934 HAWTHORNE ST. LANDOVER, MARYLAND LINDA ATKINS/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State entmant of ortant: if i injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/22/2006 CHELTENHAM. MARYLAND MARYLAND VETERAN'S 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disprase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Figal disease or condition resulting in death) CANCER OF BRAIN **Physician** months /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physicien and s the burial-transit The law requires that the death certificate be executed Storman resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical ettending physi IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. | 9□ Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes Hospital or Attending Physician: After this certific funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) llege mD 30. Name and address of person who complet ed cause of death (Item 23a) (Type, Print) 6 001 LANDOVER RD#8 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 1 5 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 3, 2006 · Physician 10:28 P м Bertram Ε. Alert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CRESCENT CITIES NURSING HOME RIVERDALE PRINCE GEORGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) South. 1942 Guyana, America 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 18 M 2□ F 220-29-0191 63 Yrs. Director June 16, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28a-f show traumatic evant, the Medical Exertine mast be notified at 1√Yes 2 No MD Prince Georges Hyattsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5702 Hamilton St. 20781 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 23 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: **Black** Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Equipment Mechanic Government 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important; if itam 27 is marked oth any linjury or other traumatic evant <u>once</u>. 18. Mother's Name (First, Middle, Maiden Sumame) Theophilus Alert Viola Lancaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvestre Yorrick/ Cousin 3120 Castleleigh Rd., Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 02/18/2006 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 4MTERIOSCEEN OBJCC **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to (or as a consequence of): The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Digbotes Millitra 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No POST-CORONARES 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Chronickela (tailore 2 XNo 1 Yes in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☑ No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Diractor; After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D01852 completed cause of death (Item 23a) (Type, Print) DELORE ULD 4203 CHOCUSTOUR Rd FURITED: 110 MID 20081 2. Registrar's Signature 31. Date filed (Month, Day, Year) State FFB 1 4 2008 Registrar

DHMH 17 Rev 1/2001

		•	State of Maryland / Department of Far State Registrar  State of Maryland / Department of Far Certificate of		tal Hygien	2000	06099
	Physici		Decedent's Name (First, Middle, Last)     Irene Grace Anderson	_N	Date of Death Month Da	3 M Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  4b. City, Town, of the control o	or Location of Death	Date of Birth	c. County of Death  Aune  9. Birth  Cou	Cae Diaf  place (State or Foreign intry)  MD
	ש	20	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Annapoli		P. 1, 13	,22	10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	with the M la or 28a-f I be notifie	Funeral Director	10e. Street and Number 2947 Broad Court 214		10g. C	itizen of What Cou USA	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23s or 28s-f show sumatic event, its Medical Examinar must be notified at	þ	11. Marital Status  1	Hispanic Origin? (Specify ) an, Mexican, Puerto Ricar Specify:	Yes or No- n, etc.)	14. Race - Amer Black, White Specify:	
	filed within 72 ho Hygiene. other then "natur ent, tre Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retire  12 Homema	i during most of working ad)	16b. k	Kind of Business/I	ndustry
yland	should be fill ind Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) George Kellenbenz	18. Mother's Name (Firs	lcher		
, Mar	ges 1 end 2 should t of Health and Mer If Item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Karen Mae Nye/Daughter  19b. Mailing Address (Street 2947 Broad C	t and Number or Rural Rou Court, Annapo			ip Code)
imore	permit. Pages 1 end 2 Department of Health a Important: If Item 27 is any injury or other tra		20a. Method of Disposition  1 □ Burial 2 ▼Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other pla	Feb. 8,	Da.	ltimore,	
Balt	permit. Departr Imports any Inji		21. Signature of Funeral Service Licensee  22. Name and Address Barranco 495 Gov.	& Sons, P.A. ritchie Hwy,	. Severna , Severna	a Park F a Park,	uneral Home MD 21146
) F	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death
	death certificate be executed XX eartending physicien and WX for use as the burial-transit UX	dical Examiner	Due to (or as a consequence of):  Carry, leading to immediate cause. Enter Underlying Cause (Disease or rigury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):	Thelian	e		Days
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S, D	w requires that: been signed by should be dete	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause growth and Black Black growth Successful Control of the Control of th	- 7 - 1	23e. Did tobacco		the cause of death?
l Rec	The law ate has b page 2 s	Completed	25. Was case referred to medical	1	24a. Was an autopsy performed?	prior to death?	opsy findings available ompletion of cause of
Ž	Physician: r this certific ral director,	To Be	examiner?	26. Place of Death (Che her: 4 ☐ Nursing Home		6 ☐Other (Spec	ıfy)
	Ing After une		27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Wo	ery at 28d. [ ork? ] Yes 2 □ No	Describe how inju	ary occurred	
-	tal or Attend 's after death al Director: , ed in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Street a City or Town, Stat	and Number or Rui te)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the ti 2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	ime, date and place, and d opinion, death occurred at	lue to the cause(s the time, date an	s) and manner as nd place, and due	stated. to the cause(s)
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7			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	eus de Co	fre Gree		72 200
~	Sta Registi	_	31. Date filed (Month, Day, Year)  32 Pegistrar's Signature	rue M	200	61	

			For AMENC#5, 10E Pestate Registrar AACO HEALT	State of Mer FH H DEPT, CMH 2/	laryland / Dep /17/06 Ce	ertificate of		nd Mental Hyg	jiene <sub>eg. No.</sub> 006	06100				
ı	Physici		Decedent's Name (First, Middle William Dou		ew			2. Date of Dear	Day Year	3. Time of Death				
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town,	or Location of	Februar	4c. County of Death					
	LXUIIII	Ü	Laurel Re	gional H	ospital	Lau			Prince 6					
	Funeral Director		5. Social Security Number 882– <del>64</del> –5985	6. Sex 7. A 1 <b>½</b> M 2□ F	ge"(In yrs. last bìrthda) 60 Yrs.	Months Days		Min. 8. Date of Birth (Month, Day)	(Year) Co.	nplace (State or Foreign untry)				
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	is 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mealth Hydene. I fleath and Mealth Hydene. I fleam 27 is marked other then "netural; or Items 23e or 28e-f show other treumstic event, the Mealten Examiner must be notified at	'n	MD Anne	Arundel	10c. City, Town or I	-ocation Pasade	ena		10d. Inside City Limi 1 ☐ Yes ※☐ N					
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	th with	al D	1008 Cape Split	Road Harbou	ır		21122		U	SA				
	er dea Items Cer m	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces ed 1 \( \sum \) Yes 2\( \sum \)		. Was Decedent of If Yes, specify Cub	Hispanic Origi ban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White					
036	iurs aft mal', or	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Wh:	ite				
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nd 2	be filed tal Hygis d other event, I	BeC	17. Father's Name (First, Middle,					s Name (First, Middle,						
Maryland	should be and Mental is marked of sumatic ev	To	Albert James A				·	ha McKinney						
Mai	nd 2 st lith and 27 is m		19a. Informant's Name/Relationsh Ben Andrew/Sor						r, City or Town, State, 2 Francisco,					
re,	ss 1 and of Health item 27 other tr	1 4	20a. Method of Disposition	-	20b. Place of Disp		- 1		20c. Location - City or					
altimore,	mit. Pages bartment of H cortent: If ite injury or or		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (Si		9	Crematory	, <u>.</u>	2006	Baltimor	e, MD				
Ball	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service	Licensee	E 4	Sariancodo 95 Gov. I	gss <i>s</i> ons, Ritchie	P.A. Seven Hwy, Seven	rna Park Fu rna Park, M	neral Home D 21146				
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Re	The lay ate has page 2	omp						autops perfori	sy prior to death?	2 No				
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of V	Physicien: this certific ral director,	၉	1⊿ Yes 2□ No	Hospital: 1 ☐ Inpat		BIR 3 DOM			ence 6 Other (Spec	cify)				
	ding T. After fune	tlon	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig		ay Year) 28b. Time Injury	We	nyat ork? ]Yes 2.∐Ni		ow injury occurred					
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	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	100-	9		se number		29d. Date signed (Month					
			Jahada	12/2/	h 00	Hz	2055	927 5	ebruara	19, 2006				
			30. Name and address of person	who impleted cause of	death (Item 23a) (Type	e, Print)	.Des	e Chero	ebruary	n Caro				
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician FEBRUARY 12 2006 3:30 P BELLAMY EARILY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HYATTSVILLE HEARTLAND NURSING HOME If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Yrs APRIL 27 1941 NORTH CAROLINA 237-68-8779 64 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County in then "natural", or Iteme 23s or 28s-f ehow the Medical Examinar must be notified at 1X Yes 2 □ No PRINCE GEORGE'S MD HYATTSVILLE Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20782 5602 CYPRESS CREEK # 103 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 123 Yes 2 □ No ARM If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after ARMY 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d Hygiene. Cottege (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT POSTAL WORKER 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ant: If item 27 is marked o AMANDA SMITH JAMES BELLAMY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5602 CYPRESS CREEK DR. # 103 HYATTSVILLE, MARYLAND NEOMIA BELLAMY/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department important: If eny injury of once. RESURRECTION CEMETERY 2/17/2006 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Servige Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner COMPLETE HEART BLOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending pl 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has 1 ☐ Yes 21 No 1 ☐ Yes 28 No Division of Vital After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 3 DOA ٩ 1 ☐ Yes ZX No 2 ER/Outpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 27 Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To use ...
within 24 hours after To the Funeral Dir To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1. man polo MD 32022 2114106 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) MENDEZ -MUNOZ HNORES 2100 PENNSYLVINIA AVENUE N.W. WASHINGTON, DC 2. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 5 2006 Registrar

**ORIGINAL** 

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		-	1- State of Maryland	-	artment of Health and Natificate of Death	Mental Hygier	2006	06102
	Physicia		1. Decedent's Name (First, Middle, Last)  Ca-l Bickel				Day Year <b>2006</b>	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)  Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	4b. City, Town, or Location of Death Annapolis If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Anne Arur  9. Birthp	place (State or Foreign
	Funeral Director		352-28-9756	Yrs.	Months Days Hours Min.	July 3, 19	936 Illii	ntry)
	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Mudical Evantural must be notified at	by Funeral Director	Maryland   Prince George's   Bowi  10e. Street and Number  16011   Pennant Lane  11. Marital Status   12. Was Decedent Ever in U.S.	13	10f. Zip Code  20716  Was Decedent of Hispanic Origin? (S	pacify Yas or No-	Citizen of What Cou  USA  14. Race - Amen	can Indian,
5-0036	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or Items raumatic event, the Medical Examination		1 ☐ Never Married 2 ☒ Married 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes, Give Year or Dates:	6a Dece	If Yes, specify Cuban, Mexican, Puert  1 Yes 2 No Specify:  dent's Usual Occupation	o Hican, etc.)	Black, White, Specify: White	te
2121	iled within 72 lygiene. her than "na nt, the Medis	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+  17. Father's Name (First, Middle, Last)	(Give life.	kind of work done during most of world DO NOT use retired)  Pastor  18. Mother's Nar	ne (First, Middle, Maic	Church	
Maryland	should be fi nd Mental F marked ot umatic ever	To Be	Carl Gerald Bickel	19b. Maili		bel Sarah 1	Holloway	o Code)
Baltimore, Ma	Pages 1 and 2 ient of Health a nt: If Itam 27 Is ry or other trai		Shirley Bickel / Spouse  20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	e of Disp	011 Pennant Lane osition (Name of matory or other place) Church nity Episcopal Cem	Date 20c	ryland 20 Location - City or T Bowie, Man	
Balti	permit. Pages: Department of the Important: If Its any Injury or of once.		21. Signature of Funeral Service Licensee	. 2	2. Name and Address of Facility Bea	all Funera . Bowie, l		Approximate
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)	~~	-19	o Hospitatory arrest,		Interval Between Onset and Death 2 w C C K S
8760,	n = 2	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (of as a consequence of the consequen		cance			3 921/3
.O. Box 68	ne death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ath 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year
<u>α</u>	v requires that the bean signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting	ng in the	underlying cause given in Part I.		co use contribute to	
al Reco	iician: The law requ certificate has been rector, page 2 shoul	Completed				24a. Was an autopsy performed 1 Yes 2	prior to c death?	opsy findings available ompletion of cause of
Division of Vital Records,	ding Physician: h. After this certific funeral director,	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ath (Check only one)  Home 5 Residence  28d. Describe how		ify)		
Divisi	affe □ Dir	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)			28f. Location (Stree City or Town, S	îtate)	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowl on the desired examination and manner stated.	edge, dea n and/or i	th occurred at the time, date and plac nvestigation, in my opinion, death occ 29c. License number	urred at the time, date	and place, and due  Date signed (Monti	to the cause(s)  n. Day, Year)
	8		30. Name any address of sperson who completed cause of death (Itam 2	(3a) (Type	D 15181	7 Fo	s. 12	2006 UM U
	St	ate	31. Date filed (Month, Day, Year)  22. Registrar's Signature of the State of the St		132 Holiday CT	7 201	An-aprl	alm u

			For 1 = State Registrar	State	of Marylan		artment of I		nd Men		ene 0 0 6	06103		
	Physici	an	1. Decedent's Name (First, Midd						- 1	Date of Death Month	Day Yeer	3. Time of Death		
	/Medic	al	FLINT		SHER		4b. City, Town,	or Landina of		BRUAR	ARY 10, 2006 9:15P M			
	Examin	er	4a Facility Name (If not institution SOUTHERN MARY)					NTON	I Death		1	GEORGES		
	Funeral	16.31	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8. [	Date of Birth Month, Day,		thplace (State or Foreign		
	Director		579 50 5402	XXM 2□F	65	Yrs.	Months Days	Hours	Min. Al	$JG \cdot 12$	, 1940 NOF	RTH CAROLINA		
	D >		Usual Residence of Decedent  10a. State 10b. Count		10c Cit	y, Town or Lo	ocation					10d. Inside City Limits		
	faryla • ho	ō		, CE GEORGES		PER MA						txtTYes 2 □ No		
	28a-1	Director	10e. Street and Number	JE GEORGE	, 01	I EK IIA	10f. Zip Code	-		10	g. Citizen of What C	ountry?		
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	leath certificat attending phy I for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregna	ancy					23d. Date of delivery			
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Division of	i Si fte	Certification:	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	mined 200. Pide	e of Injury - At hi ding, etc. <i>(Specit</i>	ome, farm, st fy)	reet, factory, office	•	28f.	Location (Str. City or Town,	reet and Number or F i, State)	Rural Route Number,		
_	spitel ours nerel filled		29a. Certifier 1 Certify	ing Physician: To the	ne best of my kno	owledge, deat	h occurred at the	lime, date and	d place, and	due to the ca	iuse(s) and manner a	s stated.		
	Ho Funda Jely	edical	(Check only 2 Medical one)	I Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation, in my	opinion, deat	th occurred a	at the time, da	ate and place, and du	e to the cause(s)		
	To the within 2 To the complet	ž	29b. Signature and title of certif	6			29c. Licer	se number		29	9d. Date signed (Mor	nth, Day, Year)		
-	$\overline{\Omega}$		Mille V	Ime	7		234	~206			Fasury	13, 2006		
2	2)		30. Name and address of perso	who completed call	use of death (Iter	n 23a) (Туре,	Print)	he Ros	nt Fo	rtwas	Faburn Taburn Ningth n	rongland		
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DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

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Ca.	Funeral Director		217-26-7945	1 ☐ M 2 ☐ 🏋 F	7. Ago (m/y/s		Months	Days	Hours Min.		Day Year	931		land	or Foreign
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	with th	급	10e. Street and Number	<b>۵</b> لمما			10f. Zip	Code	21702		10g. Cr	tizen of Wha	it Country	y r	
	ne 23	Funeral	304 Quailw		edent Ever in	U.S. 13.	Was Deced	dent of His	21793 panic Origin? (S	Specify Yes or	No-	14. Race - /		Indian,	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Chealth and Mental Hygiene. If Item 27 is marked other than "naturel" or Iteme 23e or 28e-f ehow or other traumatic event, the Modical Exam our multibe notified at	by Fun	1 ☐ Never Married 2 ☐ Marrie 3 🗷 Widowed 4 ☐ Divorced	Armed For	1 ☐ Yes 2 ☐XNo		If Yes, spec 1 ☐ Yes	offy Cuban	Mexican, Puer Specify:		Black, White, etc.  Specify: White				
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ž	d Mer Thank	ဥ	19a. Informant's Name/Relationsh		3 31.	10h Maili	na Address		Agnes M			or Town Sta	te Zin C	inde)	
Z Z	traul		Evelyn E. Weedo		r		Quail					le, MC			
ē,	f Heal		20a. Method of Disposition		20b.	Place of Dispo	osition (Nan	ne of		Date	20c. L	ocation - Cit	y or Tow	n, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other tra ance.		1 ☐ Burial 2 <b>②</b> Cremation 4 ☐ Donation 5 ☐ Other (Sp		State A1		,		on 2/11	/2006	Sy	kesvil	lle,	MD	
alti	permit. Departmimporta		21. Signature of Funeral Service L	icensee	1. 60	2	2. Name an	d Address	of Facility Ha	rtzler	Fune	ral Ho	ome		
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			23a. Part1. Enter the disease, or o shock, or heart failure. List of	inly one cause on e	each line.			, -		c or respirator	y arrest,		li	Approximat nterval Bet Onset and	tween
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<u>α</u>	res that igned b be deta	by PI	Part II. Other significant condition	ns contributing to d	eath but not re	esulting in the u	underlying c	ause giver	n in Part I.	23e. D	id tobacco	use contribu	ite to the	cause of	death?
rds	= v =	ed b								1	Yes 2	□ No 3[	Probab	oly 4 🗗	Unknown
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Division of Vital Records,	cian: extific ector,	Be	25. Was case referred to medical examiner?	Hospitali					26. Place of De						
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Ω	P Tit	Certification;	4 Homicide	build	ing, etc. (Spec	cify)	•			City or	Town, Stat	(e)			
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	dicai		Physician: To the Examiner: On the band man											s)
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8	Regist	rar	FEB 1	3 2006	Clour	SK.	Coorte	_							·
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Amended Item 26 per Physician 02/13/2006 Carroll County, wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1 - For State Registrar		State of Ma	irylanu /	Department of Certificate of		·	Reg. No.	06106			
Physician	1. Decedent's N	Name (First, Middle, Las	ne Blo	Loc	K		2. Date of De Month					
/Medica Examinei	4a. Facility Nan		vale Dr	ive	Ken.	or Location of De	noMD	4c. County of De.				
Funeral Director	5. Social Secur 220-46	- 3547 <sup>1</sup>	M 2☐XF 7. Age	(In yrs. last bi	Yrs. Months Days		8. Date of Bir lin. 0ct. 22	917 Was	hington, DC			
e Maryland	Usual Resident	10a. State 10b. County 10c. City, Town or Location						10d. Inside City Limit 1 ⊠ Yes 2 □ N				
h with the Mai 3a or 28a-f a st.bs. notified		Number Florence Bl	vd.		10f. Zip Code	2713	10g. Citizen of What Country? U.S.A.					
be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "natural", or Items 23a or 28a-f ahow avent, I're Medical Exercitor restly be notified at	3 □ Widow	tus Married 2 <mark>M</mark> Married red 4 □ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 5 N If Yes, Give Year or Dates:	]Yes 2. Mo es. Give		Hispanic Origin? ban, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)	14. Race - Am Black, Wh Specify:				
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygjene. 77 la marked other than "natural", or traumatic avant, the Wedfall Exuri To De Complished by	-	15. Decedent's Ed Specify only highest gra Secondary (0-12) 12			i. Decedent's Usual Occi (Give kind of work doni life. DO NOT use retir homemak	e during most of t ed)	working	16b. Kind of Busines	•			
E aga aga ag	17. Father's Na	ge Williams	Rue			Į.	Name (First, Middle ion May SI	, <i>Maiden Sumame)</i> hoemaker				
lore, Maryla ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic	19a. Informan	t's Name/Relationship (7			b. Mailing Address (Stree Florence B		Rural Route Numb DeBary, Fl		Zip Code)			
Baltimore, permit. Pages 1 and Department of Heall Important: If tiem 2 any injury or other once.		f Disposition  1 2 □ Cremation 3 □  tion 5 □ Other (Specify			of Disposition (Name of ery, crematory or other pl ount Cemete	ry 2/1	Date 11/2006	20c. Location - City of Libertytov	vn, MD			
Balti permit. Departr Importe any inji	21. Signatu e	of Funeral Service Licentary	. Warth		22. Name and Add			Funeral Hon tytown, MD				
68760, ifficate be executed XB/VIII gphysician and as the burial-transit in its properties of the principle	Immediate Cadisease or corresulting in de	use (Final notition sath)  ist conditions, to immediate Underlying se or injury wents	a. Due to for as t. Due to (or as c.	a consequence	tette	et t	Files Disect	E	Interval Between Onset and Death Y I-W S			
cords, P.O. Box 68760,  w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit.	in the pa	eedent pregnant st 12 months? 2 ⊠No nown		23d. Date of delivery Month Day								
ds, P.	Part II. Other s	significant conditions of		23e. Did tobacco use contribute to the cause								
The law rec	Complete						24a. Was auto perfe 1 □ Yes	s an 24b. Were prior to death'				
Yita yaician yaician is certifi	25. Was case examiner?	Death al 5 Pending ent investigation	28a. Date of Inju (Month, Da	ry 28b. Y Year)	Time of 28c. In Injury M 1	Other: 4 Nursin jury at Pork? Yes 2 No	28d. Describe	one 6 XOther (Sphow injury occurred  (Street and Number or				
DIVI	4 Homi	determined	28e. Płace of Inj building, et	ury - At home, c. (Specify)	farm, street, factory, offic	е	City or To	(Street and Number or wn, State)	nurai noute Number,			
Division of To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	29a. Certifier (Check or one)	Certifying Ph 2 Medical Exar	niner: On the basis o and manner st	examination a ated.		opinion, death o	occurred at the time,	, date and place, and d 29d. Date signed (Mo	nth. Day, Year)			
WIL	30 Name and	andress of person who MKINNE			(Tyge, Print) (VISCENSIN	Avenue	Chivy	Charg	8, Zero G MARY LAND			
State Registra	e ar	(Month, Day, Year) FEB 1 3	32. Registr	ar's Signature	* Sparke				Ze815			

		•	For State Registrar	State of Ma		Depa		t of H	ealth a		, ,	iene		16117	
			Decedent's Name (First, Middle, La	ist)							2. Date of Deat	h	000	3. Time of Death	
	Physici /Medic		Brady Oliver Br	yson							Month February	9 Day	2006	7:15 p M	
4	Examin	3/	4a. Facility Name (If not institution, gir	ve street and number)			4b. City,	Town, or	Location o	of Death		4c.	County of De	ath	
			260 Bell Road						inste		r		11		
i.	Funeral Director		,	Sex 7. Age 1 □XM 2 □ F	(In yrs. last t	Yrs.	Months	nder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye March 14					9. Birthplace (State or Foreign Country) Nevada		
	Maryland f show	ō	10a. State 10b. County	roll	10c. City, To		cation tmins	ter						10d. Inside City Limits 1 ☐ Yes 2♣ No	
	r 28a-	Director	10e. Street and Number			-	10f. Zip	Code			1	og. Citiz	en of What (	Country?	
	th with	a D	260 Bell Road				21158						USA		
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itema 23a or 28a-1 show event, I're Medical Exartinar must be notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 SYes 2 N If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)      □ Yes 2 No Specify:							4. Race - An Black, Wh Specify:	nerican Indian, hite, etc. White	
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu ent, tre Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5		ia. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Lawyer						16b. Kir	nd of Busines Lat	,	
land	should be filed nd Mental Hyg marked other imatic event,	To Be C	17. Father's Name (First, Middle, Las Samuel Oliver Br		· · ·						e (First, Middle, M Brady	łaiden i	Sumame)		
	and and is m		19a. Informant's Name/Relationship Mary Bryson/wife		15		og Address O. Bo				al Route Number, ninster,		Town, State, 21158		
Baltimore,	Pages 1 and 2 ant of Health ht: If Item 27 i y or other tre		20a. Method of Disposition  1 Burial 2 Stremation 3 [ 4 Donation 5 Other (Speci			tery, crer	sition (Naminatory or o	ther place	· .		2006		ation · City o	or Town, State	
Balti	permit. Pages Department of H Important: If Ite any injury or of		21. Signature of Funeral Service Lice	-		1 P	Nemean ritts	d Address	eralit	HOM:	e and Ch d Westm	ape.	l, P.A	D 21157	
760,	be executed by which is a second of the seco	Ical Examiner	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. According to the cause of one cause on each line.  Due to (or as a contract of the contract	e.  /eu a consequence	ke of):	er the mode		g, such as	cardiac (	or respiratory arre	sst,		Approximate Interval Between Onset and Death  Week	
P.O. Box 68	that the death certifica led by the attending ph detached for use as tt	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)   9   Unknown   9   Unkno									23d. Date of delivery Month Day				
	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death bu	ıt not resulting	g in the u	nderlying ca	ause give	n in Part I.		23e. Did tob			to the cause of death?  Probably 4 Unknown	
al Records,	The fa	Completed									24a. Was a autops perform	y ned?	24b. Were prior to death?		
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 4 🗔 I i -		2 .		Othe			h (Check only on				
o	Physic rithis gral dia	To To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injur	nt 2 ER/0	. Time o		8c. Injury Work	4 🗆 Nu		me 5 Reside			pecify)	
on	nding F th. : After e funera	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М		? /es 2 □ !	No					
Division	al or Atters after des il Directorid in by the	Certification:	3 Suicide 6 Could not determined		ry - At home, . (Specify)	farm, str	eet, factory	r, office			28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifying P (Check only one)  Certifying P 2 Medical Exe	hysician: To the best of miner: On the basis of and manner sta	examination :	lge, deati and/or in	n occurred vestigation,	at the tim , in my op	e, date and inion, deat	d place, th occur	and due to the cared at the time, da	use(s) ate and	and manner place, and d	as stated. ue to the cause(s)	
	To t To t	ž	29b. Signature and title of certifier					License						nth, Day, Year)	
)	1151		Ewenhaa	140				000	629	75		211	0106		
	W13		30. Name and address of person who Fathy Weishow	- 295 Sto	ner A	ve:	#307		estr	uns	ster Mi	21	157		
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 3	2006 32. Registra	r's Signature	×	porti	,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 14 Year **Physician** Benjamin Russell Beeman 2006 5:33 P <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner sacred Heart Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 29 1928 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**№** M 2□ F 215 20 7141 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits in than "neturel", or Items 23a or 28e-1 show the Medical Examiner must be notified at MD. Allegany Midland XXYes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 14815 Railroad St. 21542 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
snt: If item 27 le marked other than "neturel", or Items 23, 1ry or other traumatic event, the Medical Examinal must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 X Yes 2 No
If Yes, Give Korean 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Painter unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William G. Effie Beeman C. Beeman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Schrout/ friend 14815 Railroad St., Midland, Maryland 21542 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State rtment c Flintstone, Maryland Maryland Vet. Cemetery injury <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Boal Funeral Home permit.
Dep rtm
Importe
any inju 21 Signature of Funeral Service Licensee 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Amythmia ARDIAC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed cabete Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No lon after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2XX€R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To XXYes 2 🗌 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funarel ( filled To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who comprehed cause of death (Item 23a) (Type, Print) Pellegrino 31. Date filed (Month, Day, Year) MD 32. Registrar's Signature State FEB 1 2008 Registrar

			For State Registrar	State of Ma	ryland .	-	artment of F			Reg. No.	06	06109
	Physicia		1. Decedent's Name (First, Middle, La Ria Dicker Bu	<sub>st)</sub> tler					2. Date of De Month Februar	Day	2006	3. Time of Death 4:30P. M
	/Medic Examin		4a. Facility Name (If not institution, gir Renaissance Gardens (d	e street and number) Riderwood Vil	lage		4b. City, Town, o	Location of Death			unty of Deat	eorge's
	Funeral Director		Social Security Number 6.3		(In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	th v Year)	9. Birt	hplace (State or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George's	10c. City, T	own or Lo						10d. Inside City Limits 1 ☐ Yes 2 🔊 No
	h with the	Funeral Director	10e. Street and Number 3160 Gracefield l	Road, #1223			10f. Zip Code 20904			10g. Citizen Unite	of What Co	•
o-00-c	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of the Trie markled other than "natural", or tlems 23a or 28a-f show any injury or other traumatic avent, the Madical Examiner must be nutified at once.	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Black, Whit	nican Indian, e, etc. Mite
0-6171	within 72 ho lene. than "natur he Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (2-22)	ducation ade completed) College (1-4or 5-		(Give life.	dent's Usual Occup kind of work done DO NOT use retired Nemaker	ation during most of work d)	ing		of Business	
yiand 2	id be filed ental Hygi ked other ic avent,	To Be C	17. Father's Name (First, Middle, Las Reuben	Di	cker			18. Mother's Nam Belle	e (First, Middle		mame) inter	
Mary	nd 2 shou alth and M 27 ie mar r traumati	-	19a. Informant's Name/Relationship Valerie J. Kaplan					and Number or Rur				Zip Code)
gaitimore,	Pages 1 and the pent; if item ury or other	and the state of t	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		<sup>(ce)</sup> 2/11/	Date 2006	20c. Locat Denvei		Town, State Lorado			
Dait	permit. Departi		21. Signature of Funday Service Life	Wante		ad Belt	SVILL	e, PA e, Mar	yland 20705			
	Physician /Medical		23a. Part 1. Enter the disease, or conshock of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line  a. Menin  Due to (or as a	gioma		ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury	b. Due to (or as a								
8/60,	icate be executed physicien and s the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequer	nce of):						
O. Box 68	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal de	eath 3[	□Ectopic pregnanc	,		23d	. Date of de	ivery Day Year
1	requires that the reen signed by th hould be detache	5	Part II. Other significant conditions	contributing to death bu	t not resulti	ng in the u	inderlying cause giv	ren in Part I.	1			o the cause of death?
II Kecords,	The la ate has page 2	Completed							24a. Was auto perfo 1 ☐ Yes		prior to death?	utopsy findings available completion of cause of
y Vital	Physician: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1  Inpatier			nt 3□ DOA Oth	4 ZENursing Ho	ome 5 Res	dence 6		cify)
Division of	r Attending P er death. rector: After I by the funera	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	De Os - Disea of Injur	Year)	Bb. Time o	Wor	y at rk? Yes 2 □ No	28f. Location			ural Route Number,
<u>≥</u>	<ul> <li>Hospitel or Attending 124 hours after death.</li> <li>Funerel Director: After letely filled in by the fune</li> </ul>		4 Homicide determined	building, etc	. (Specify)			me date and place	City or To	wn, State)		
	To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Example)  29b. Signature and title of ceptifier	miner: On the basis of and manner sta	examination	n and/or in	vestigation, in my o	opinion, death occur	red at the time,	date and pla	ace, and due	to the cause(s)  th. Day, Year)
	12		30 Name and address of person who	Stude	eath Grants	MD 3a) (Type		3649				.0, 2006
			John Stuckey, M.	20 0	- Ci			r Spring,	Maryla	nd 209	904	
100	Sta Regist		31. Date filed (Month, Day, Year) FEB 14 7	2006 Registra	Signatur J	- Car	arles					

		State of Maryland / Department of Health and N  State of Maryland / Department of Health and N  Certificate of Death	Mental Hygiene	
		Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death
Physic /Med		NOKIE E. BAKER	FEBRUARY	
Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c.	County of Death
		2266 BRIDLE PATH DRIVE WALDORF		CHARLES
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Director		230-12-6796	FEB.4,19	10 WEST VIRGINIA
pu *		Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or Location		10d. Inside City Limits
sho	ō	MARYLAND CHARLES WALDORF		1 □ Yes 2√□ No
he N	Director	10e. Street and Number 10f. Zip Code	10g Citi	izen of What Country?
with				
eath	era	2266 BRIDLE PATH DRIVE  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	S. A. 14. Race - American Indian,
fter d	Funeral	1 Never Married 2 Married 1 □ Yes X No	Rican, etc.)	Black, White, etc.
urs a	þ	If Yes, Give 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed ※ ☒ Divorced Year or Dates:		Specify: WHITE
If yiellid Z I Z I D-0000 should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural", or Items 23s or 28e-f show matic event, the Medical Examination must be notitified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	16b. Ki	ind of Business/Industry
hin 7	pie	Elementary/Secondary (0-12) College (1-4or 5+)	9	
filed with Hygiene ther the	Con	8 HOMEMAKER		N HOME
be file	Be (		e (First, Middle, Maiden	Sumame)
should be nd Mental marked our	10	CHARLES WILBURN HARMON JULAN	<del> </del>	
and and is mum	y 3	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	al Route Number, City o	r Town, State, Zip Code)
and and sealth m 27 m				ORF, VD 20601
of He		20a. Method of Disposition 2 Paragraph from State cemetery, crematory or other place)		ocation - City or Town, State
ILITION  II. Pages  Introduct of  ortent: If it  njury or o		'4 □Donation 5 □Other (Specify) ROSELAWN MEMORIAL CEM. 2-2	4-200€ PR	INCETON, WV
Datiffice, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Licensee MOO 179 22. Name and Address of Facility RAYMOND FUNERA		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Dhyaiaian		shock, or heart failure. List only one cause of each line. Immediate Cause (Final		Onset and Death
Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of)	S-2-54	123
Examiner		Corneral da A la		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
uted	트	cause. Enter Underlying Cause (Disease or injury that initiated events  c. Cayn arts fall		
be executed ician and burial-transit	Examiner	resulting in death) Last  Due to (or as a consequence of):		
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certificat	edi			
that the death certificated by the attending phetached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
the death y the attentiched for u	cia	in the past 12 months?  4 Pregnant at time of death 5 Other (specify)		Month Day Year
ache the C	hys	9 Unknown		
	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?
HECOTOS he law requires e has been sign			1 ☐ Yes 2	No 3 Probably 4 ☐Unknown
law rec	Completed		24a. Was an	24b. Were autopsy findings available
The la	E		autopsy performed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
- # d	CO	25. Was case referred to medical 26. Place of Deal	1 ☐ Yes 2 ☐ No th (Check only one)	1 Yes 2 No
	o Be	examiner?	ome 5 Residence	6 □Other (Specify)
P P Silf F	h	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how inju	
On ding Afte	tior	1 ∰Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		
OIVISION  or Attending after death.  Director: After in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office		nd Number or Rural Route Number,
after Dir.	erti	4 ☐ Homicide building, etc. (Specify)	City or Town, State	5)
DIVISIO  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the to	Medical C	29a. Certifier  (Check only (Check only a Check only (Check only a Check only a Check only a Check only (Check only a Check only a Check only a Check only (Check only a Check	and due to the cause(s	) and manner as stated. d place, and due to the cause(s)
n 2 n 2 of	Med	one) and manner stated.  29h Sinnature and title of certifier / /// 29c. License number	29d Da	te signed (Month, Day, Year)
		29b. Signature and title of certifier 29c. License number	2	120/04
To the I within 2. To the I	i	Transfer I all the state of the	and the same of th	
To the To the Comp		VIN 0 feel 0000031		100100
To the within to the to the to the		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	202	10000
5	tate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mi chall Leatherwood, Mb 12000 old Live Center, S  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ste. 302, W	aldorfmo zacz

DHMH 17 Rev 1/2001

		4	1 - State 2-15-06 Registrar Amend #26	State o	f Marylan		artment of rtificate o			dental Hy	ygiene Reg. No.	006	06111	
	Physici	an	Decedent's Name (First, Middle	e, Last) SE ESTEBAN	1	C.L.				2. Date of D Month	eath Day 2/10/	Year	3. Time of Death	vI
	/Medic Examin	4	4a. Facility Name (If not institution				4b. City, Town	n, or Location	of Death			County of Dea		
	Examin	eı	SHADY GROVE AI	-			ROCKV	ILLE			MO	NTGOMER	<b>XY</b>	
	Funeral Director		5. Social Security Number 220-43-2667	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs.		If Under 1 Ye Months Da		Min.	8. Date of B (Month, D 08/04)	irth (ay, Year) (1951	9. Bir Cc <b>NIC</b>	thplace (State or Foreig untry) CARAGUA	חן
	P _		Usual Residence of Decedent											_
	Marylar a-f show	tor	MD 10a. State 10b. County			y, Town or La <b>MANTOW</b>		,					10d. Inside City Limit	
	h the	Director	10e. Street and Number				10f. Zip Cod	e			10g. Citi	zen of What Co	ountry?	
	th wit	aD	18234 SMOKE HOU	JSE COURT			208	374			NICA	RAGUA		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified.	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	ned 1 ☐ Yes	2 📆 No /e		Was Decedent of Yes, specify C	Luban, Mexica	an, Puerto	RAGUA		14. Race - Ame Black, Whit Specify: HI		
Maryland 21215-0036	within 72 h ene. than "natu	Completed		nt's Education est grade completed) College (1	1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re	ne durina mo	st of work	ang		nd of Business	/Industr <b>y</b>	
7	filed w Hygier other th			4		PA	STOR	10 14-1		- /Ci-s Middl	CHU			
/land	should be filed and Mental Hygir is marked other aumatic event, II	To Be	17. Father's Name (First, Middle, JOSE ANTONIO CI							e (First, Middl CASTRO	e, Maiden	Sumame)		
	and 2 sho ealth and I m 27 is me		19a. Informant's Name/Relations SARA BLANCO de		wife)		ng Address (Str Smoke							
lore,	Pages 1 and the pages 1 and th		20a. Method of Disposition 1   Burial 2 □ Cremation			emetery, crei	sition (Name of matory or other		02/1	Date		cation - City or		
Baltimore,	permit. Pages 1 am Department of Heal Important: if item 2 any njury or other once.		4 □ Donation 5 □ Other (5		1	22	NTAL  Name and Ad  KENNE		litySan	ta Cru	z Ser	vicios	CARAGUA Funerarios 20011	
8760,	Physician /Medical Examiner private its pr	ai Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	mplet	uence of):  vence of):  tage	hear h	J per ena	Jen.	lock sion	allest,	rl	Approximate Interval Between Onset and Death	~ ~
P.O. Box 687	Physicien: The law requires that the death certificate this certificate has been signed by the ettending phyyral director, page 2 should be detached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregna birth 2 Teta nant at time of d own	Ideath 3	]Ectopic pregna ] Other (specify				2	23d. Date of de Month	livery Day Year	
	uires that signed b Id be deta	d by Pi	Part II. Other significant conditi	ions contributing to de	eath but not res	ulting in the u	nderlying cause	given in Parl	1.				the cause of death?	n
Recol	he law req e has beer age 2 shou	mpiete		1						per	opsy formed?	prior to death?	utopsy findings available completion of cause of	е
a	n: T ificat or, pa	ပိ	25. Was case referred to medica					OS Dia	no of Dool	1 Yes	2 No	1 Yes	2 No	
5	/sicié s cert lirect	To B	examiner?	Hospital:	Inpatient 2 🗀	ER/Outpatier	nt 3 004	Othor		th <i>(Check only</i> ome 5 ☐ Res		S □Other (Spe	cifu)	_
O	y Phy ar this eral c	n: T	27. Manner of Death	28a. Date	of Injury	28b. Time o		njury at Work?	. 3. 3. 19 . 10	28d. Describe			,/	
Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	th, Day Year)  Un record to be of Injury - At he ing, etc. (Specif	ome, farm, str	18M	1 🗆 Yes — <del>2 [</del>	ZNo-	28f. Location City or To	(Street and	d Number or R )	ural Route Number,	
_	Hospitel	edical Ce	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the I Examiner: On the b and man	e best of my kno asis of examina ner stated.	wledge, deat tion and/or in	h occurred at th vestigation, in r	e time, date a	and place,	and due to the	e cause(s) , date and	and manner as place, and due	s stated. a to the cause(s)	-
	To the within 2 To the complet	Me	29b. Signature and title of certific	er A			29c. Lic	ense numbe			29d. Dat	e signed (Mont	h, Day, Year)	_
			· Panha	1 (al	M.D		D	396	15		FEB	RUARY	11 2006	Š
_	(2)		30. Name and address of person	LAL	111	19	Ro y	MLLE		PILE	#	100	ROCKVILL	<u>_</u>
**	Sta		31. Date filed (Month, Day, Year		Registrar's Signa	ILUFO	K.						190 2085	> 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a, perInf. (353, 3/2/06/III) State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb 8, **Physician** Year Blanche Coleman 2006 6:25 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days | Hours | Min. | (Month, Day. Montgomery 5. Social Security Number (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Sept 12, 1 1 M 2 F 577-24-3730 Director 1912 Calvert Co MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Completed by Funeral Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 5326 2nd St NW United States 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specity: Specify Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Elevator Operator 4 i. Pages 1 and 2 should be filed vitneric of Health and Mental Hygie tant: If Itam 27 is marked other fully or other traumatic event, It. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anderson Paris Isabell Kyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Youce Suggs/ Granddaughter 8466 Kingsway Dr. White Plains MD 20695 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Ft Lincoln Cemetery NEXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Feb 15, 2006 Bladensburg MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityPope Funeral Home 21. Signature of Funeral Service Licensee 2617 Penn Ave SE Washington DC 20020 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 Day IsDiratia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes XX No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature an Ltitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45660 30. Name and address of person who completed cause of death (them 23a) (Type, Print) 0/5 ROWIG 124 FOX C

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State

Registrar

143001

31. Date filed (Month, Day, Year)

FFB 1 6 2006

CALCANT

			1 - State	rtment of Health and Mental I	2000 00112
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No. U U U U U U U U U U U U U U U U U U U
	Physici		Kathleen B. Clements	Febr	
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Wilson Health Care Center	Gaithersburg	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month	, Day, Year) Country)
ŀ.	Director		578-05-1384 94 Yrs. Usual Residence of Decedent	July	13, 1911 South Carolina
	yland		10a. State 10b. County 10c. City, Town or Loc	ation	10d. Inside City Limits
	e Mar	ctor	MD Olney Montgomery		1X Yes 2 ☐ No
	ith th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	ral	4120 Mt. Olney Ln	20832	USA
	72 hours after death with the Maryland 'natural', or Items 23a or 28e-f show dical Examirer must be profified at	<b>Funeral Director</b>	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 2 No.	Vas Decedent of Hispanic Origin? (Specify Yes o Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian, Black, White, etc.
036	urs af	þ	3 Wildowed 4 □ Divorced If Yes, Give 1  Year or Dates:	☐ Yes 2√√ No Specify:	Specify: White
21215-0036	72 ho natur	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry
2	Aithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)	
	iled w Hygiei ther ti	S	12 2 Home	emaker  18. Mother's Name (First, Mic	Own Home
and	d be f antal l ced o	To Be	Lee V. Brown		
Maryland	shoul nd Me mark	F		Willie Penning  Address (Street and Number or Rural Route No.	
	alth a 27 is			Mt. Olney Ln. Olney, M	
ore,	as 1 a of He of He item		20a. Method of Disposition 20b. Place of Dispos		20c. Location - City or Town, State
<u><u><u></u><u><u> </u></u></u></u>	Page ment ant: If ury o		1 Strain 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Columbia	1	Arlington, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other traumatic event, It a Madical Examiner must be natified at page.			Name and Address of Facility	O Wilson Blvd. Arl., VA
			23a. Part1. Enterthe disease, or complications that caused the death. Do not ente shock, or hear failure. List only one cause on each line.	r the mode of dying, such as cardiac or respirato	2203 ry arrest, Approximate
k	Physician :		Immediate Course (Fine)		Interval Between Inset and Death
	/Medical		disease or condition resulting in death)  a.   New Movie    Due to (or as a consequence of):		TWEEK
	Examiner		Sequentially list conditions b.		
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or argury		
_	and and II-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8760,	death certificate be executed attending physician and of for use as the burial-transit	dical E			
687	ificate g phy: as the	edlo	d		
Вох	leath certifica attending ph I for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Live birth 2 □ Fet	Estania aragnana.	23d. Date of delivery
	that the death cer ed by the attendin detached for use	sicla	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	Month Day Year
P.0	at the	Phy	9 Unknown		
S,	se ugu	by	Part II Other significant conditions contributing to death but not resulting in the unit	1400	Did tobacco use contribute to the cause of death?  Yes 2 > 0 3 Probably 4 Unknown
Ö	w requir been si should	etec	Dementing) Memoriner 3		72
Vital Record	The tav	Completed		a	Vas an utopsy erformed? 24b. Were autopsy findings available prior to completion of cause of death?
<u>a</u>		e Cc	25. Was case referred to medical	1 \( \text{Y} \)	es 210 No 1 Li Yes 210 No
	00 ·-	OB	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check or 3 DOA Other: 4 Nursing Home 5 F	Residence 6 Other (Specify)
0	ng Ph ter th	n: T	27. Manner of leath 28a. Date of Injury 28b. Time of		ibe how injury occurred
000	Attending r death. ector: After by the funer	atlc	2 Accident investigation	M 1 Yes 2 No	
Division of	of Attending Phy after death. I Director: After this d in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre-building, etc. (Specify)	et, factory, office 28f. Locatio City or	on (Street and Number or Rural Route Number, Town, State)
	Hospitel of hours a Funeral C		Continue Continue Charles Table 1	4	
	To the Hospitel or Attentwithin 24 hours after deatl to the Funeral Director: Sompletely filled in by the	edical	29a. Certifier Certifying Physician: To the best of my knowledge, death (Check only Edward Examiner: On the basis of examination and/or invene) one) and manyfer stated.	occurred at the time, date and place, and due to estigation, in my opinion, death occurred at the tir	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To the within 2 To the Somple!	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	(2)		& Komas Wil browles un	2 DO052401	February 13 2006
	TAN		30. Name and address of person who completed cause of death (Item 23a) (Type, P	(rint)	Silver Spring. MI
	Ets		Thomas M. Annulis, M.D., 1080	1/Lackwood Drive; Jui	1005, 20901
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature		,
			FPR 1 5 9006 Reserve & A	Marie Committee of the	

DHMH 17 Rev 1/2001

			1 - For State Registrar		State of	of Maryla					ealth a	and M	lental Hy	gien	CUUD	0	6114	
			Decedent's Name (First)	Middle, Last)									2. Date of De	aath			. Time of Death	_
	Physici /Medic		SYLVIA				C	OLE	MAN						12, 2006		1:20 P M	1
	Examin	er	4a. Facility Name (If not in:			imber)					Location o	of Death			c. County of De			
	<b>-</b>		6116 BREEZEW  5. Social Security Number	OOD COL		7. Age (In yi	s. last hirthe	_		NBEL'	$\Gamma$	24 Hrs.	8. Date of Bi		RINCE GI		E (State or Foreigi	_
	Funeral Director		226-78-8587		м 2 <b>К</b> 1 F	55	Yr	M	lonths	Days	Hours	Min.	(Month, Da	ay, Yea	7)	Country)		,
	P .		Usual Residence of Deced											1,550	J V 11			_
	ehow	'n		County INCE GI	EORGE		City, Town o		ion								Inside City Limits 1 ⊠Yes 2 □ No	
	the M	ect	10e. Street and Number			- OR			10f. Zip (	Code				100.0	itizen of What C			_
	3a or	Funeral Director	6116 BREEZEW	OOD COI	IR <b>T</b>			'		0770				iog. c	U.S.			
	death	nera	11. Marital Status		12. Was Dec	edent Ever in	U.S.	13. Was	s Decede	ent of His	spanic Orig	gin? (Sp	ecify Yes or No	)-	14. Race - Am	nerican Ir	ndian,	_
9	or its	/ Fu	1 Never Married 2		Armed Fe 1 ☐ Yes If Yes, Gi	2/CXNo			Yes 2		Specify:	, Pueno	Rican, etc.)		Black, Wh			
Ö	within 72 hours atter death with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow the Medical Exantirar must be notified at	d by	3 Widowed 4 Di		Year or D	Dates:	10- 5							1				_
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212	d with giene. r the	lmo	Elementary/Secondary (	0-12)	College (	1-4or 5+)		CCO.	UNTA	ANT				PF	RIVATE			
밀	al Hyg	Bec	17. Father's Name (First, M	Aiddle, Last)						- 1	18. Mothe	r's Name	(First, Middle					
yla	ould to	To	SIDNEY JOHN										GOODH					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Martal Hygiens. Depertment of Health and Martal Hygiens instruction of Health 27 is marked other then "naturel", or iteme 23s or 28s-f ehow mortain: if item 27 is marked other then "naturel", or iteme 23s or 28s-f ehow any injury or other traumatic event, it a Marical Esantration that be notified at once.	ıΝ	19a. Informant's Name/Re MICHAEL COLE												or Town, State,		le)	
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<u> </u>	Dermi Deper Impo any ir		K. D.	M	rall								NDOVER					
Ξ			23a. Part1. Enter the disc shock, or heart failure	ase, or complice. List only on	e cause on	caused the de each line.	ath. Do not	enter th	he mode	of dying	, such as	cardiac o	or respiratory a	rrest,		Inte	roximate rval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	MET	ASTATI	C BREA	AST	CANC	CER						Ons	set and Death	
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9 xo	death certifica	Physician/Me	IF FEMALE:	2:	3c Ifves ou	tcome of preg	nancy											
Bo	etten for u	clan	in the past 12 months	arit	1 Live	ointh 2 ☐ Fe nant at time of	tal death		topic pre						23d. Date of de Month	Day	Year	
o.	that the de led by the e detached t	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkn													
o. O.	igned be det	by P	Part II. Other significant c	onditions con	tributing to d	eath but not re	esulting in th	e under	rlying ca	use give	n in Part I.		23e. Did t	obacco	use contribute t	to the car	use of death?	
ğ	w require been si should b	ted						<del> </del>					10	Yes 2	2 □ No 3 □ P	robably	4 XUnknown	
ပို	aw 2 s 2	Completed											24a. Was		24b. Were a	utopsy fi	indings available	
<u> </u>		Co											perfo 1 ☐ Yes	rmed? 2 X N	death?			
<u> </u>	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to n examiner?		ospital:					Other	_		Check only o					_
ō	문 후 등	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	-	28a. Date	of Injury	☐ ER/Outpa 28b. Tim		3 DOA	1	4 🗆 1901		ne 5🏋 Resident		6 Other (Spe	ecify)		_
<u>o</u>	Attending P ir death. ector: After by the funer	atlor		Pending nvestigation	(Mon	th, Day Year)	Inju	ry	м	c. Injury Work' 1   Y	? es 2 □ N				.,			
Division of Vital Records,	I or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place	of Injury - At ing, etc. (Spe	home, farm	, street,	factory,	office			28f. Location (: City or Tox	Street a	nd Number or R	ural Rou	ite Number,	_
ā	ital or A																	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ☒ Co (Check only 2 ☐ Me	ortifying Phys edical Examin	er: On the b	asis of exami	nowledge, d nation and/o	eath occ r investi	curred at igation, i	t the time in my opi	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s date an	s) and manner and place, and du	s stated. e to the	cause(s)	
	within 2 To the comple	Med	29b. Signature and title of	certifier	and man	ner stated.			29c.	License	number			29d. Da	ate signed (Mon	th. Dav.	Year)	
	r s r o		Sugar	Leuc	ett-)	John	on h	Au		8149					13/06	-71		
0	(10)		30. Name and address of p	erson who con	mpleted cau	se of death (It	em 23a) (Ty	pe, Print	nt)									
_			SUSAN LEGGET					EST	RD	TAYH	TSVI	LLE,	MD 207	82				_
75	Sta Registra		31. Date filed (Month, Day,	Year) 4 2008		legistrar's Sig	nature	her	وخو									

			For State Registrar	State of M		artment of rtificate o		and Mental Hy	giene	6 (	06115
	Physici	an	1. Decedent's Name (First, Middle,					2. Date of De Month		Year	3. Time of Death
	/Medic	al	WILLIAM FRANK CI					FEBRUA			4:30P M
	Examir	er	4a. Facility Name (If not institution, g CLINTON NURSING		1		n, or Location of LINTON	of Death	4c. County		CORGES
	Funeral				ge (In yrs. last birthday	) If Under 1 Yea	ar If Under	24 Hrs. 8. Date of Bi			ace (State or Foreign
	Director		579 38 3364	<b>X</b> ZM 2□F	73 Yrs.	Months Day	ys Hours	Min. 8. Date of Bi (Month, Di OCT • 2	4, 1932	NORT	H CAROLINA
	and ww		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
	Maryl f sho	tor	MD PRINCE	GEORGES	FORT WAS						XXYes 2 □ No
	r 28a	Director	10e. Street and Number	0_0110_0		10f. Zip Code	8		10g. Citizen of \	What Count	ry?
	J within 72 hours after death with the Maryland Jiene. Ir than "naturel", or Itama 23a or 28a-1 show The Medical Evantrel must be nutified at	al D	6914 EAGLETON LA	ANE			2074	4	UNIT	ED ST	ATES
	er des Itams	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Ori Juban, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	o- 14. Rad Blad	e - America ck, White, e	
35	Irs aft	by	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	MXYes 2☐ If Yes, Give Year or Dates:	No	1□Yes XXN	No Specify:		Specify	BLAC	K
5-0036	72 hou	Completed	15. Decedent's	Education	16a. Dece	edent's Usual Occ	cupation	t of working	16b. Kind of B	usiness/Ind	ustry
7	within iene.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	e kind of work do DO NOT use ret		t or working			
7	a filed w I Hygiel other ti		17. Father's Name (First, Middle, La	1 YR.	CO	MPOSITOR	1	er's Name (First, Middle			ERNMENT
and	ed la b	To Be	BEN CHAMBERS					HARRELL	i, ivialueri Surrian	16)	
ary	s 1 and 2 should be f Health and Mental item 27 Is marked other traumatic ev	Ĕ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stre		er or Rural Route Numb	er, City or Town,	State, Zip	Code)
Σ	5 = 2 I		SHIRLEY M. CHAM	BERS/ WIFE	6914	EAGLETON	N LN.	FORT WASHI	NGTON, M	D 207	44
ore	Pages 1 a nent of Hez int: If item iry or othe		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other p	olace)	Date	20c. Location -	City or Tov	vn, State
aitimor	t. Pag rtment rtent: rjury o		`4 □Donation 5 □ Other (Spe	cify)	MARYLAND				CHELTE		
g	permit. Pages Department of I Importent: If ite any Injury or of		21. Signature of Funeral Service Lic	Olonsee				ERAL HOME			
l.			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each li		4308 SU3 ter the mode of d			TLAND, Murrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		CLEROTIC C	CARDIOVAS	SCULAR	DISEASE			Onset and Death
	Examiner				a consequence of):						
	D =	ner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to for as	a consequence of):						
	be exacuted ician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
8/60,	icate be exacuted physician and s the burial-transit	calE		Due to (or as	a consequence or).						
20	ificate g phys as the	ᇹ		d				-			
ZOZ	requires that the death certificate een signed by the attending phys hould be detached for use as the	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregnar	DCV			te of deliver	*
	ne deat the att hed fo	Physicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□Unknown		Other (specify)			Mo	nth [	Day Year
ĭ	that the de ed by the detached		Part II. Other significant condition:	s contributing to death b	out not resulting in the	underlying cause	given in Part I.	23e. Did	tobacco use cont	ribute to the	cause of death?
ecoras,	w requires that s been signed b should be det	d by				, ,			Yes 2□No	3 Proba	bly XXIUnknown
် ပ	> 0 0	ompleted						24a. Was	an 24b. \	Were autop	sy findings available
Ľ	0 4 0	omo					_	auto perfo	ormed?	orior to com death? □Yes 2	pletion of cause of
	ysician: The is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place	of Death (Check only			
_	hys this	은	1 ☐ Yes XXNo		ent 2 EP/Outpatie			rsing Home 5 Resi			
	ding Pt n. After th funeral	tlon:	27. Manner of Death  XXNatural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju (Month, Da	y Year) 28b. Time o		nuryat Vork? □Yes 2□I		how injury occurr	ed	
VISION	ten deatl tor: the	flcat	3 Suicide 6 Could no	be 28e. Place of Inj	jury - At home, farm, st			28f. Location (	Street and Numb	er or Rural	Route Number,
2	after s after I Dire	Certification;	4  Homicide	building, et	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State)		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (	29a. Certifier XX Certifying (Check only one)	Physician: To the best eminer: On the basis of	of examination and/or in	th occurred at the	time, date and y opinion, dea	d place, and due to the th occurred at the time,	cause(s) and ma date and place,	nner as sta	ited. the cause(s)
	To the H within 24 To the Fi complete	Mec	29b. Signature and title of certifier	and manner st	ated.	29c. Lice	ense number		29d. Date signed	(Month, D	ay, Year)
	- 3 - 5		n 601			D	45365		FEBRUA	RY 15	. 2006
2	((-)		30. Name and address of person wh	o completed cause of c	death (Item 23a) (Type						
1	$\mathcal{Q}$		MICHAEL SIDA				N RD. 🖅	101 FT. W	ASHINGTO	N, MD	20744
	Sta Registr		31. Date filed (Month, Day, Year) FFB 1 6 20	Registr	rar's Signature	all I					
	riegisti	u	LEBIO 50	00	1						

DHMH 17 Rev 1/2001

				•	-	rtment of I tificate of				g. No. 0 (	) 6	06116		
Physi		1. Oecedent's Name (First, M	and the same	arcene Cook				2.	Date of Death Month Februar	Day y 14, 200	Year 6	3. Time of Death 7:00 a.m.		
/Med Exam		4a. Facility Name (If not institu					4b. City, To	wn, or Locati		4c. County				
			Egle Nursin	g Home			Lo	naconin	g		Alleg	gany		
Funera Directo		5. Social Security Number 232-26-0446	6. Sex 1 □ M 2 1 1	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under:	24 Hrs. 8. Min.	Date of Birth (Month, Day, January 14,	Yea <i>r)</i> 1920	9. Birthp Coun We	lace (State or Foreig try) St Virginia		
pur *		Usual Residence of Decedent  10a. State 10b. Cou		100 City	, Town or Loca	ation								
Aaryla r sho	5	755. 550	· ity	Too. Oily	, TOWITOI LOCA						1	0d. Inside City Limits 1 💢 Yes 2 🗆 No		
the A	ect	Maryland 10e. Street and Number	Allegany			10f. Zip Code	Lonacon	ung	10	Citimen of l	A/h = A Co			
with with	ā					Toi. Zip Code	21520		10	g. Citizen of V	unat Coun USA	•		
death ms 2:	Funeral Director	11. Marital Status	57 Jackson St	ecedent Ever in U.S	S. 13. W	as Decedent of F	21539 Hispanic Orio	gin? (Specify	Yes or No-	14. Rac	e - Americ			
be filed within 72 hours after death with the Maryland tital Hygiene. of other then "natural", or Items 23a or 28a-f show event, the Medical Examinar must be nythed at	þ	1 Never Married 2 N 3 Nover Married 2 N 3 Nover Married 2 N	Armed farried 1 ☐ Ye If Yes,	Forces?	lf':	Yes, specify Cub ☐ Yes 2 No	an, Mexican Specify:	, Puerto Rica	an, etc.)		k, White,			
72 ho	ted	15. Dece	dent's Education		16a. Decede	nt's Usual Occup	ation		16	Sb. Kind of Bu	siness/Inc			
thin 7	Completed	Elementary/Secondary (0-1)	thest grade complete  College	e (1-4or 5+)	(Give ki life. Do	nd of work done  NOT use retire	during most d)	of working						
filed with Hygiene. ther ther	ြပ္ပ	12		,		Но	memak	er			Own h	ome		
o da bo	æ	17. Father's Name (First, Midd	fle, Last)				18. Mothe	r's Name <i>(Fi</i>	rst, Middle, Ma	<i>iden Sum</i> am	e)			
should be ind Mental i marked o umatic eve	ဥ		Edgar F	Feller					Mar	cia Smith	l			
C1 62 60 60	4	19a. Informant's Name/Relation	onship (Type, Print)		19b. Mailing	Address (Street	and Numbe	or Rural Ro	oute Number, (	City or Town,	State, Zip	Code)		
of Health item 27 i			lanco/daughte				940 Par	adise St.	, Midland	, MD 21	542			
		20a. Method of Disposition 1 X Burial 2 ☐ Crematic	on 3 □ Bemoval fro		ace of Disposi metery, crema	tion (Name of utory or other plac	ce)		ate 20 ary 17,	c. Location -	City or To	wn, State		
men ment: ant:					Mt. Vi	ew Cemeter	ry		006	Mos	cow M	ills, MD		
Dependent Dependent Importation any in	1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Mt. View Cemei  21. Signature of Funeral Service Licensee  22. Name and Add  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of or								n-McKen ning, MD		al Hon	ne P.A.		
		23a. Part1. Enter the disease,	or complications that	at caused the death.	. Do not enter	the mode of dyir	ng, such as o					Approximate Interval Between		
Physician /Medical		Immediate Cause (Final disease or condition a. Immediate (Final disease or												
Examiner		resulting in death)	Due to (or as a consequence of):											
ש. ש	ner		ROX	-hinsons	d1 500						1	UNICALI		
ecute and trans	Examiner	Sequentially list conditions,	0		as a conseque	ence of):				<u>.</u>				
oe ex cian a		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J								1			
ificate be executed g physician and as the burial-transit	edical	that initiated events resulting in death) Last	)	Due to (or	as a conseque	nce of):								
ding			d								1			
eath certificate be executed attending physician and for use as the burial-transit	by Physiclan/M													
the d	ıysi	Part II. Other significant cond			ting in the und	erlying cause giv	en in Part I.		23b. Did toba	icco use con	tribute to	the cause of death		
that ned b	y P	SIJPYI 0	tempn +12					_	1 🗆 Yes	2 Ū∕No	3 🗌 Prob	ably 4 ☐ Unknow		
To the Hospitel or Attending Physiclen: The law requires that the death cert within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Completed b								24a. Was an a performe	autopsy d?	ava	re autopsy findings ilable prior to opletion of cause eath?		
he ia te ha age	E O								1 ☐ Yes	2010		Yes 2□ No		
en: ] tifice tor. p	Be C	25. Was case referred to medi-	cal				26 Place/	of Death (Ch	eck only one)	23110	, ,	163 2010		
Physiclen: r this certific ral director.	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	☐ Inpatient 2☐ E	R/Outpatient	3□ DOA Oth	nr. /		5 ☐ Residend	e 6 ∏Othe	r (Specify	)		
Attending Ph or death. ector: After th by the funeral	ertification:	Z I Troordon	28a. Dat ding stigation	1	28b. Time of Injury	28c. Injun Worl		28d.	Describe how			,		
tel or Atters es efter de al Directo ed in by the	Certific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	rmined 266. Pla	ce of Injury - At hom Iding, etc. (Specify)	ne, farm, street	t, factory, office		28f. l	ocation (Stree City or Town, S	et and Numbe State)	r or Rural	Route Number,		
To the Hospitel or I within 24 hours efter To the Funeral Dire completely filled in b	edical	29a. Certifier 1 ☐ Certify (Check only one)	BIEXaminer: On the	ne best of my knowi basis of examination anner stated.	ledge, death occurred at the time, date and place, and due to the cause(s) and ron and/or investigation, in my opinion, death occurred at the time, date and place						ner as sta nd due to	ated. the cause(s)		
To the To the COM	Σ	29b. Signature and title of certif				29c. License	number		29d	Date signed	(Month, D	ay, Year)		
		pense?	noun			100	913)	)	12	14	06			
2		30. Name and address of person		use of death (Item 2	23a) (Type, Pri									
,	1 1	11600 Bin	Lun Alier	CUWL	How M	0 010	1							
4		31. Date filed (Month, Day, Yea	4.1700	04.191	1									

LB1	ERT CAW	LEY	. For	State of Mar	yland / Dep	artment of Hea	alth and M	ental Hy	gieņe	06117
		•	1 - State Registrar		Ce	rtificate of De	eath		Reg. No. UUD	UDIII
	Physicia	an	1. Decedent's Name (First, Middle, Last	)				2. Date of Dea Month	ath Day Ye	
	/Medic		WILBERT HARRY CAN			45 65 7	tion of Dooth	Februa	ry 17, 20	
	Examin	er	4a. Facility Name (If not institution, give	_	. 1	4b. City, Town, or Lo	cation of Death			eatti
7	<b>.</b>	7	Country Club Road  5. Social Security Number 6. Se		Road In yrs. last birthday		Under 24 Hrs.	8. Date of Birt	Talbot 9.	Birthplace (State or Foreign
	Funeral Director		217-42-5514	<b>X</b> M 2□ F	63 Yrs.	Months Days F	Hours Min.	NOV. 2	9. 8, 1942	MARYLAND
	P		Usual Residence of Decedent	'	0- 0's T					10d. Inside City Limits
	anylar ehow	_	10a. State 10b. County		Oc. City, Town or L	XFORD				1 ☐ Yes <b>3</b> (☐ No
	Ba-f	Funeral Director	MD TALBO	OT	U	10f. Zip Code			10g. Citizen of Wha	
	a or	ក	10e. Street and Number	0.17		216	55%			SA
	na 23	era	4820 EVERGREEN R	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, M		cify Yes or No		American Indian,
(O	or iter	Fu	1 ☐ Never Married 2 😿 Married	Armed Forces? 1 ∰Yes 2 □ No If Yes, Give				Hican, etc.)		Vhite, etc.
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or itema 23e or 28e-f ehow the Medical Examiner must be motified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 🛣 No S	Specify: 		Specify:	WHITE
2	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	(Give	dent's Usual Occupation kind of work done during		ng	16b. Kind of Busine	ess/Industry
7	within noe.	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)  PRESIDENT			LAWN & L	ANDSCAPING
i D	illed within Hygiene. other then	ပ္ပိ	17. Father's Name (First, Middle, Last)				3. Mother's Name	(First, Middle,	Maiden Sumame)	
Maryland	d be ental ked o c eve	To Be	WILBERT HARRY CAW	LEY, SR.			SARAH	MARTHA	DOTY	
37	s 1 end 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. Item 27 is marked other then "naturel", or fleme 23e or 28e-f ehow other traumatic event, the Medical Examiner must be multiled at	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mail	ing Address (Street and	Number or Rura	l Route Numbe	er, City or Town, Sta	te, Zip Code)
	end 2 Balth a n 27 is		DEBORAH L. CAWLE	Y/WIFE	482	O EVERGREEN				
ore	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of omatory or other place)	, .	ate	20c. Location - City	or Town, State
Ĕ	Peges ment of ant: If it		4 □Donation 5 □ Other (Specify,		OXFORD C		2/24/	2006	OXFORD,	MARYLAND
Baltimore,	permit. Peg Department Important: I eny injury o		21. Signature of Funeral Service Licens		_ F	2. Name and Address of ELLOWS, HEI	LFENBEIN	& NEWN	IAM FUNERA MD 21601	L HOME PA
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused th	e death. Do not er					Approximate interval Between
	Physician		Immediate Cause (Final disease or condition	a MULTIE	LE 1	NOVRIES				Onset and Death
	/Medical Examiner		resulting in death)		consequence of):					
	Examine	_	Sequentially list conditions.	b. Due to for as a	consequence ol):					
	per list	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a t	consequence or,					
	axecu and al-tra	Examiner	that initiated events resulting in death) Last	CDue to (or as a	consequence ol):					
8760,	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	cal		d						
Ö	tificat og phy as th	led								
Box	th cer tendir r use	an/h	23b. was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic pregnancy			23d. Date of Month	delivery Day Year
	it the death certif by the attending tached for use at	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	ne of death 5	Other (specify)				,
0	that the		Part II. Other significant conditions co	entributing to death but	not resulting in the	underlying cause given i	in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
Records,	signed of be de	d by						10	Yes 2 No 3	] Probabiy 4 □Unknown
Sor	w require been si should l	lete						24a. Was	an 24b. Wer	e autopsy findings available
Be	he lav e has age 2	Completed						autor perfo	rmed? deat	r to completion of cause of h? Ƴes 2□ No
tal		0	25. Was case referred to medical			26	6. Place of Death			
<b>\</b>	Physicien: The this certificete har director, page	To B	examiner? 1 Ž¥yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatie	ont 3□ DOA Other:			dence 6 🗷 Other (	Specify) scene
0	Attending Physicien: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day)		Work?			how injury occurred	COLLISION
sio	tendi death. tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be	2/17/06	8.	ION -	3 223110			r Rural Route Number.
Division of Vital	l or Al efter o Direc i in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc.		riedi, lactory, onice		City or Tox	wn, State) Ti	CXFORD RD, MD
	To the Hoapital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of	xamination and/or i	th occurred at the time, nvestigation, in my opini	date and place,	and due to the	cause(s) and manne	er as stated.
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	und manifel state		29c. License no	umber		29d. Date signed (A	fonth, Day, Year)
	⊢ <b>≶</b> ⊢ ô		Duoto	1		OCME			February	18, 2006
-			30. Name and address of person who o		ath (Item 23a) (Type	, Print)				,
7	Alca			310, 70		111 Penn S	Street,	Baltimo	ore, Marla	nd 21201
	Sta Registi		31. Date filed (Month Day, Year) 200	R. Registrar	s Signature	sele!				

			1 - For State o	f Maryland / Depa		Health and	- 1	-	6 06118
н	Physici	ian	1. Decedent's Name (First, Middle, Last) William D	Cogan			2. Date of Dea Month	Dav	3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give street and nur Sacred Heart Hospital		4b City, Town Cumber	or Location of De Land	Feb 11		of Death Legany
	Funeral Director		5. Social Security Number 6. Sex 207-32-5158 11分M 2□ F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Yea Months Day		lrs. 8. Date of Birtlin. 12-18-1	(941)	Birthplace (State or Foreign Country)     PA
9	within 72 hours after death with the Maryland ene. then 'netural', or itams 23a or 28e-1 show Ita Mailcal Exaritrar: sast be nuitified at	Funeral Director	Usual Residence of Decedent  10a. State PA Somerset Co  10e. Street and Number  306 Old Wittenberg Rd.  11. Marital Status PA Never Married  12. Was Decedent   ident Ever in U.S. 13.1	10f. Zip Code 15552 Was Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		e - American Indian, ck, White, etc.	
Maryland 21215-0036	e filed Il Hygi othar vant, I	Be Completed by	3 Widowed 4 Divorced If Year or D  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1)  17. Father's Name (First, Middle, Last)	16a. Dece (Give iife. i	dent's Usual Occ kind of work don DO NOT use reting	upation e during most of sed) Cher 18. Mother's N	Name (First, Middle,	16b. Kind of Bu Public Maiden Surnam	White usiness/Industry Schools
Maryla	2 should and Mer is marke eumetic	2	Robert Cogan  19a. Informant's Name/Relationship (Type, Print)				Rural Route Numbe	r, City or Town,	
Baltimore, I	Pages 1 and nent of Health ant: if itam 27 ary or othar th		Robert Cogan  20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	sition (Name of natory or other pi	ace)	Rd., Meyer Date .4-2006 M		City or Town, State
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	TCC0376 22	. Name and Add	ress of Facility.	and the second s	Funera	1 Home, Inc.
8760,	And the primary interpretation and primary inter	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events . c.	or as a consequence of):  or as a consequence of):  or as a consequence of):		•	нас от гезриалогу ат	<del>93</del> 1,	Approximate Interval Between Onset and Death UK YTS
Box 6	death certific e attending p id for use as	Physician/Med	in the past 12 months?	ant at time of death 5	Ectopic pregnan Other (specify)	су	500 	23d. Dat Mor	te of delivery nth Day Year
ecords, P	The law requires that the ate has been signed by th page 2 should be detache	þ	Part (I. Other significant conditions contributing to de	eath but not resulting in the ur	nderlying cause g	iven in Part I.	23e. Did tol	1-1	ribute to the cause of death?  3  Probably 4 Unknown
al Reco	: The law re cate has be , page 2 sho	Completed					24a. Was a autops perform	ned?/	Were autopsy findings available prior to completion of cause of death?
of Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?  Yes 2 □ No  Hospital:	anotions 2 P/Outration	4E 204 0	thor	eath (Check only on	100	
	To the Hospital or Atlanding Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the Luneral director, page	atlon; To	27. Manner of Death 28a. Date of	npatient 2 ER/Outpatien of Injury h, Day Year)	28c. Inju	4 🗆 Nursing	g Home 5 ☐ Reside 28d. Describe ho		
É	ital or Atta irs after des rai Directo led in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home, farm, streng, etc. (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	er or Rural Route Number,
	To tha Hospital within 24 hours a To tha Funaral I completely filled	Medical	29a. Certifier 1 ☐ Certifying Physician: To the (Check only one) Addicel Exeminer: On the ba and maps 29b. Signature and title of certifier	siś of examination and/or inv	restigation, in my	time, date and pla opinion, death oc use number	curred at the time, d	ate and place, a	and due to the cause(s)
	M I I	_	111	a of death /Nom 33a) (Time 1	D091		2	Feb 11	1 (Month, Day, Year) 2006
			30. Name and address of person who completed cause Paul Snow M.D. Dtpy Med			umberlar	ad MD 2150	2	
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)   32. Ri	egistrar's Signature	Small o				

			1 - For State Registrar		ryland / Dep Co	artment o			Rec	ene	<u> </u>	06119
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  ELIZABETH L. CO	OOK	·				2. Date of Death Month FEBRUARY	Day 16	2006	3. Time of Death 8:54PM <sup>M</sup>
	Examir	er	4a. Fecility Name (If not institution, give to TALBOT HOSPICE HO			4b. City, To	wn, or Location EASTO				nty of Death <b>TALBOT</b>	
	Funeral Director		210-30-3702	7. Age	(In yrs. last birthda 66 Yrs.		Year If Unde Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day, ) 0CT 31	(ear) <b>939</b>	9. Birthpla Count MARY	ace (State or Foreign (y) LAND
	aryland Bhow	L.	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or						10	d. Inside City Limits
	the Mi	recto	MD TALBO  10e. Street and Number	<u>T</u>	Е	ASTON 10f. Zip Co	ode		100	ı. Citizen o	of What Count	1 ☐ Yes <b>XX</b> No
	23a ol	al Di	9516 ENTRANCE LA	NE			21601				USA	
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23 or 28a-f show other traumatic event, the Medical Exercise frings by notified at	by Funeral Director	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	ver in U.S. 13	. Was Deceden If Yes, specify 1 ☐ Yes 21			ecify Yes or No- Rican, etc.)		ace - America fack, White, e	tc.
215-0	hin 72 ho s. an "natur Medicul	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed) Colfege (1-4or 5-	(Giv	edent's Usual C e kind of work o DO NOT use i	done durina mo	ost of worki	ing 16	ib. Kind of	Business/Ind	ustry
21	filed wit Hygiene other the	Соп	12	0		HOMEMAK					HOME	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, The Ma	To Be	17. Father's Name (First, Middle, Last)  CHARLES HENRY RA	АВ			18. Mot		e (First, Middle, Ma NITA JUNE		-	
Mar	d 2 sho th and 7 is mu traum		19a. Informant's Name/Relationship (Ty						al Route Number, (			Code)
altimore,			JAMES L. COOK/HU  20a. Method of Disposition  1 ABurial 2 Cremation 3 CR		20b. Place of Dis	osition (Name ematory or othe	of r place)	0		c. Location	n - City or Tov	
Itim	permit. Page Department Important: II any injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		WOODLAW	N MEMOR			20/2006	EAST	CON, MD	
B	Dep Imp		JOHN R.			FELLOWS	, HELFE	NBEIN	W & NEWNA	M FUN	NERAL B	OME PA
Physician /Medical Examiner    Contain   Conta												Approximate Interval Between Onset and Death
8/60,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	- Due to (or as a	consequence of):	Renat	disc	care				
O. Box 6	death certifi e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetaf death 3	□Ectopic pregr □ Other <i>(speci</i> i					Date of delivery Month E	y Day Year
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions con	tributing to death bu	not resulting in the	underlying caus	se given in Part	11.				cause of death?
Vital Records,	i: The law requires that the cate has been signed by the page 2 should be detache	Completed							24a. Was an autopsy performe		prior to com death?	y findings available pletion of cause of
	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospitaf:	t 2□ER/Outpati	ent 20 DOA			ne 5 Residence	<del>X</del>	ther (Specify)	HOSPICE
DIVISION OF	nding Phy th. : After this e funeral d	<b>&gt;</b>	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time		Injury at Work?	2	28d. Describe how			HODITOL
DIVIS	pital or Attencous after deathers after deatheral Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y · At home, farm, s (Specify)	treet, factory, of	ffice	2	28f. Location (Stree City or Town, S	et and Nun State)	nber or Rural i	Route Number,
	Hos Hos ely	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner state	examination and/or i	th occurred at to	he time, date a my opinion, de	and place, a	and due to the caused at the time, date	se(s) and n and place	nanner as state, and due to t	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	MD			cense number	559	7 29d	Date sign	ed (Month, De	ey, Year)
1	100		30. Name and address of person who co	157 A1	ath (Item 23a) (Type	Print)	has	- /	ene EA	cho	m!	1/60/
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 1 2006	32. Registrar	's Signature	e contraction	- V 1	i du	THE CIT	J / U/1	11116	a. T.

		1	For State Registrar	State of I		epartment of F Certificate of			giene 006	06120
	47	ş45.	Decedent's Name (First, Middle	o, Last)				2. Date of Dea	ath Day Year	3. Time of Death
	Physicia /Medic		Marion Courtne	ey				Feb.	9, 2006	10:45a <sup>™</sup>
)	Examin		4a. Facility Name (If not institution	, give street and number	er)	4b. City, Town, o	r Location of Death		4c. County of Deatl	n
254			Genesis Elder C		Age (In yrs. last birtho		rna Park	8. Date of Birt	h a Riel	Arundel  hplace (State or Foreign
	Funeral Director		100-24-7092	1 M 2 XF	95 Yr	Months Days	Hours Min.	Sep. 2	y, Year)   Co	untry) NY
100	T		Usual Residence of Decedent							404 1-14-02 1111
	arylan show	_	MD Anr	ne Arundel	10c. City, Town o	Severna 1	Dark			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	8a-f	ecto	10e. Street and Number	ic Ardiner		10f. Zip Code			10g. Citizen of What Co	
	a or 2	ă	253 Berrywood	Drive			1146			SA
	ma 23	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was Decedent of H		pecify Yes or No		rican Indian,
9	or ite	교	1 Never Married 2 Marr	Armed Force 1 Tes 2 If Yes, Give		1 ☐ Yes 2 ANo		nican, etc.)		hite
2-003	within 72 hours after death with the Maryland ene. then "ratural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date					16b. Kind of Business/	
Ϋ́ Ϋ́	n 72 h "nati	lete	(Specify only higher	t's Education st grade completed)		ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of work	king	New York	
2121	iene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Secre	tary		Youth Boar	-
	al Hygie other vent.	Bec	17. Father's Name (First, Middle,	Last)					Maiden Sumame)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.  is marked other then "natural", or itema 23a or 28a-f show ammatic event. If a Mexical Examinating must be notified at	10	George Horey					len Keni		***
Jar	12 shon and 7 is m		19a. Informant's Name/Relations Maureen Belka						er, City or Town, State, 2 a Park, MD	
	1 and Healt em 2		20a. Method of Disposition	- Baugireer	20b. Place of D	isposition (Name of		Date	20c. Location - City or	21146 Town, State
JOH.	ages ant of nt: If it		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		318	crematory or other pla Crematory	1	2006	Baltimore	. MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic en		21. Signature of Funeral Service			22. Name and Addre	ss of Facility		erna Park Fi	***************************************
	20E # 3		23a. Part1. Enter the disease, or	HICEN	read the death. Done	495 Gov. I	<u>Ritchie H</u>	wy, Seve	erna Park, N	MD 21146 Approximate
			shock, or heart failure. List	only one cause on eac	th line.	t enter the mode of dys	ng, such as cardiac	or respiratory a	irost,	Interval Between nset and Death
	Pnysician /Medical		disease or condition resulting in death)		as a consequence of	h-	Na			nours
100 m	Examiner			PRY	cohoro	l vaso	ou lar	dis	ease	MRGCS
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of	C . C. C.			C-10 C	U
	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	) c						
8760,	oe exe cien a ourial-		resulting in death) Last	Due to (or	as a consequence of	):				
	physics the t	edical		d						
Box 6	eath certific attending p	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		205-1			23d. Date of de	
	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ 100		h 2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _			Month	Day Year
P.0	at the by th	hys	9 Unknown				. Is Beat	23a Did	obacco use contribute to	the cause of death?
	res that the de signed by the a be detached f	by	Part II. Other significant conditi	ons contributing to dea	th but not resulting in	ne underlying cause gr	ven in Parti.	1		robably 4 Jonknown
Örc	law requires as been sign 2 should be	eted	-/II tilear	161 3	9,000	770		24a. Was	an 24h Were au	utopsy findings available
Records,	The law ate has I page 2 s	Completed						auto	prior to death?	completion of cause of
Vital	ician: T certificati rector, pa	a)	25. Was case referred to medical	ıl			26. Place of Dea			20110
ί	1/4	ToB	examiner? 1 Tes 2 No	Hospital: 1 🗆 Ing	patient 2 ER/Outp	patient 3 DOA	her: 4 1 Nursing H	lome 5 ☐ Resi	dence 6 Other (Spe	cify)
n of	ding Phy Ih. After this funeral c		27. Manner of Death 1 CNatural 5 ☐ Pendi	ilg.	Injury 28b. Ti Day Year) In	ury Wo		28d. Describe	how injury occurred	
sio	tor	icati	3 Suicide 6 Could	not be 280 Place of	f Injury - At home, fare	m, street, factory, office	]Yes 2 □No	28f. Location (	Street and Number or R	ural Route Number,
Division	after after Direction by	Certification:	4 Homicide determ	building	g, etc. (Specify)	n, 31100t, 120tory, 511150		City or To	wn, State)	
	To the Hospital or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physician: To the base and manner	is of examination and	death occurred at the t for investigation, in my	ime, date and place opinion, death occu	and due to the urred at the time,	cause(s) and manner at date and place, and due	s stated. e to the cause(s)
	To the l within 2 To the complet	Mec	29b. Signature and title of certific		O /	29c. Licen	se number	7~	29d. Date signed (Moni	th, Day, Year)
					V	M(1) (	10010	X	d-10	- 2006
			50. Name and address of person	who completed cause	of death (Item 23a) (T	ype, Print) For	nother.	, M.U	orsvilla 1	41/2/100
·	C)	ate ·	31. Date filed (Month, Day, Year	1 100	gistrar's Signature	11000	Juli al	1 110	1 37.06	.,
	Regist		FEB 1	3 2006	m &	Soul				

	w		1 - For State Registrar	State of M	aryland		artmen tificate			and M	F	Reg. No.	06	061	21
	Dhusiai		1. Decedent's Name (First, Middle, Las	t)							Date of Dea     Month	ith Day	Year	3. Time o	f Death
	Physici /Medic		HYO SOOK CHANG								FEBRUARY			4:45	P M
	Examin	er	4a. Facility Name (If not institution, give		)				Location o	of Death			nty of Death		
			SHADY GROVE ADVENTIS		na //a le	ast birthday)	If Under	(VILLE	If Under:	24 Hrs	9 Date of Birth		CGOMERY O Bigh	plana (Ctata	or Foreign
	Funeral Director		213 27 7001	M 2 □ F 7. A		55 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 9/28/19	, Year) 50	KORE	place (State ontry) A	or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
	Mary	ō	MARYLAND MONTGOMER	Y	ROCE	KVILLE								1 🖺 Yes	2X No
	288-	ec.	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Cou	ntry?	
	3a or	ā	14021 PELLITA TERRA	CE			2	20850				KOREA	4		
	death me 2	Jera	11. Marital Status	12. Was Decedent		S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	ace - Ameri		
9	after or its	by Funeral Director	1 Never Married 2 Married	Armed Forces  1 ☐ Yes 2 🖄  If Yes, Give			1 ☐ Yes			i, Fuelto	riiodii, oto.)	Spec	lack, White,		
93	ours	d by	3 Widowed 4 Divorced	Year or Dates:				2 3 140					- AU	IAN	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or itema 23e or 28e-f ehow a Medical Examinar musi be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced (Give	kind of wo	rk done d	uring most	t of worki	ng	16b. Kind of	Business/In	dustry	
121	within ne.	E G	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT us E MAKEF		,			OUNT I	IOME		
2	filed v Hygie other i		12 17. Father's Name (First, Middle, Last)			поги	L PIAKEI		18. Mothe	r's Name	(First, Middle,	OWN H			
anc	ntal led o	Be.	HYUNG GANG KIM								SUN OH		,		
Maryland	2 should be filed withir and Mental Hygisne. is marked other than surmatic event, the Ma	ဥ	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe	r, City or Tow	m, State, Zij	code)	
Za Za	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Ifem 27 is marked other than "natural", or itame 23e or 28e-f ehow other traumatic event, the Medical Exercities must be rediffied at		DANIEL D. CHANG - SO			14021	PELLIT	CA TER	RRACE;	ROCKV	ILLE MD	20850			
Ja,	s 1 and 2 of Health item 27 i		20a. Method of Disposition		CE	ace of Dispo	sition (Nan	ne of	9)		)ate	20c. Location	n - City or T	own, State	
9	Pages nent of a nrt: If it		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		9	LINCOL	-			2/15/	2006	BRENTW	700D, M	)	
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licen	see / / 0 / 0	0	22	. Name an	d Addres	s of Facilit	y 118	300 NEW H	AMPSHTRE	AVENIII	7	
ä	F 5 5 8		Ilylin !	blobe	4	н	NES-RI	NALDI	FH		VER SPRI				
760,	Physician /Medical Examiner who sicien and physicien are physician and physician and physician are physician and physician are physician are physician and physician are physician are physician are physician and physician are physician and physician are p	cal Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	A	a conseque	uence of):	atera	u s	cler	2120				Interval Be Onset and	
P.O. Box 687	requires that the death certificate een signed by the attending phys hould be deteched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Z No 9 ☐ Unknown	23c. If yes, outcom  1 Live birth  4 Pregnant a	2 ☐ Fetal at time of de	death 3[ eath 5[	Ectopic pr Other (sp	pecify)				,	Date of delive	Day	Year
	res th igned be de	ρ	Part II. Other significant conditions of	ontributing to death	bul not resu	Ilting in the u	nderlying c	ause give	en in Part I.		23e. Dia to	obacco use co 'es 2 □ No			unknown
ord	w require been si should I	eted													
Records,	sician: The law certificate has b irector, page 2 st	Completed									24a. Was autop perfor	sy	prior to co death? 1 \(\sum \text{Yes}\)	opsy findings ompletion of a 2 No	avallable cause of
Vital	ian: artifica ctor, I	Be	25. Was case referred to medicat examiner?						26. Place	of Death	(Check only o	ne)			
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 Inpat		ER/Outpatier			4 🗀 Nu		me 5 Resid			ly)	
ū	ing P	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time o Injury		28c. Injury Work			28d. Describe h	low injury occ	urrea		
Division	r Attending I er death. rector: Atter by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At ho	me, farm, str	meet, factor		Yes 2 🗆		28f. Location (S City or Tow		mber or Run	al Route Nun	nber.
Ö	itaio Irsaft raiDi	Cer													
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		ysician: To the bes niner: On the basis and manner s	of examinat		vestigation	, in my op	oinion, dea		ed at the time,	date and plac	e, and due t	o the cause(	s)
	With To t	Σ	29b. Signature and title of certifler	/ M.D.			1	c. License		~	-	29d. Date sign			
	[]		Cobut Knowl	har				10	265	>	1	ebrum	10,	1006	
	(3			completed cause of	·										
	A		31. Date filed (Month, Day, X ar)	Holmes 32 Regis	990 trar's Signa	1 Med:	ical (	Cent	er Dr	: R	ockvill	e, MD	20850		
10 A	Sta Regist			006	ers L	y Ap	and I	5							

			1 - For State Registrar	State of Maryla		artment of I		d Mental Hy	Com	006	06122
			Decedent's Name (First, Middle, Last	)		inoute or	Dodin	2. Date of De	Reg. No.		3. Time of Death
	Physic		Rosemary	Cecilia	Can	non		Februa	Day	Year	
	/Medi Exami		4a. Fecility Name (If not institution, give		Can	4b. City, Town, o	or Location of D			, 2006 ounty of Deat	1:26 AM
	Exami	ler						oatii			
	Funeral		Civista Medical C 5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year	ata If Under 24	Hrs. 8. Date of Bi		harles	hplace (State or Foreign
	Director		-	IM SETE	S5 Yrs.	Months Days		Ain. (Month, Da	ay, Year)	Co	untry)
			Usual Residence of Decedent		J			May 8,	1920	Pen	nsylvania
	anyiano		10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	Mar	to	Maryland Charle	c	Pomfre	+					1 ☐ Yes 2 ☑ No
	th the Marylar or 28a-f ehow	Director	10e. Street and Number	<u> </u>	1011111	10f. Zip Code			10g. Citize	n of What Co	untry?
	th with 23a or	0	4331 Columbia Par	k Road		206	75			.S.A.	•
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. \			(Specify Yes or No uerto Rican, etc.)		. O . A . Race - Ame	ncan Indian.
ထ	or ita	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No	'	f Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)		Black, White	
8	urs o	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		S	pecify:	hite
21215-0036	72 hours elter death with the Maryland natural', or Itams 23a or 28a-f ahow alical Examiner must be notified at	Completed	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occup	oation		16b. Kind	of Business/	
2	within 7 ene. then "r	ple	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	working	:		,
21	D	ě	12	Conlogo (1 401 54)	Sec	retary/Bo	ook kee	per		Cleri	cal
		Q	17. Father's Name (First, Middle, Last)					Name (First, Middle	, Maiden Si		541
<u>ಹ</u>		ToB	Unknown O'Neil	1			lin	known			
Maryland	d 2 should be th and Mental th amarked of treumatic av	-	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street		Rural Route Numb	er. City or 1	own. State. Z	in Code)
Ž	7572		Kathleen Stockman-	Daughton				Road, Pom			
5	4 9 E 3	. :	20a. Method of Disposition		. Place of Dispo-	sition (Name of	200	Date		tion - City or	
2	t. Pages 1 tment of Ha tent: if iten		1 Burial 2 Cremation 3 F		-	natory or other pla	· 1	10 006			
Baltimore,	artme ortan injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Eugeral Service Ucens		untt Cre			. 13, 200			, Maryland
Ba	Departm Departm Importa eny inju		21. Signature of Party Service Gloris	<u>™</u> M01391	22	Name and Addre	V/457+25	3035	01d Wa	ashing	ton Road
			The Board San			untt Fune		me POB 1	56, Wa	aldorf	MD 20604
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de le cause on each line.	eath. Do not ente	17		/	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Conge	Are t	reary	ta	-/wre			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or assa cons	equence of):				-		
	Examiner		Sequentially list conditions,								
	ם א	Examiner	if any, leading to immediate	Due to (or as a cons	equence of).						
	nd rans	am	Cause (Disease or injury that initiated events								
Ö,	e exe ien a urial-	m	resulting in death) Last	Due to (or as a cons	equence of);						
8760,	cate be executed physicien and the burial-transit	dlcal									
9	rtifice of pt as t	Med	In results								
Вох	death certifi e ettending I id for use as	2	230. Was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Estania avanasa.			230	d. Date of deli-	very
	deat e ett	lcle	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Ectopic pregnancy Other (specify)	/ 			Month	Day Year
P.0	that the ed by th detache	hys	9 Unknown	9□ Unknown							
	w requires that the de been signed by the c should be detached t	by Physician/Me	Part II. Other significant conditions con	tributing to death but not re	esulting in the un	derlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
Records,	equires sen sign lould be							1 🗆 '	Yes 25	No 3 ☐ Pro	bably 4 Unknown
8	w re	Completed						24a. Was	20	24b Wara aud	anny findings available
æ	sician: The law certificete hes l irector, page 2 s	m						– autop	rmed?	prior to c death?	opsy findings available ompletion of cause of
ल	n: T ficete or. pa		OF Man and other day					1□ Yes	2 2 No	1 🗆 Yes	2□ No
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ō	> 07 T3	ပို	1 Yes 2 No	1 Ennpatient 2	ER/Outpatient		4 ( IAUISIII)	Home 5 Resid			ify)
E C	Jing After fune	on	1 KNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe I	now injury o	ccurred	
Division of	Attanding I ar death. actor: Alter by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be	20 81	1		Yes 2 □ No				
<u>&gt;</u>	or A lifter Dirac in by	ŧ	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, tarm, stre	et, factory, office		28f. Location (S City or Tox	Street and N vn. State)	lumber or Rui	al Route Number,
J	S in S		20- 0	1							
	Hospli 24 hour Funari tely fille	Medical	(Creck Only 2   Madical Examili	ician: To the best of my kiler: On the basis of exami	nowledge, death nation and/or inv	occurred at the tin estigation, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time.	cause(s) an	d manner as	stated. to the cause(s)
	To the within 2 To the complet	Med	3.10)	and manner stated.	^	.,,					
	1 × 1 × 0	-	29b. Signature and title of dertifier	Matt	<i>y</i>	29c. Licens			∠9d. Date s	igned (Month	
			r Mau	v (w)			522	-87	2	113	2006
	1 -		30. Name and address of person who co							•	
1	05		Nalin Mathur, MD, 10	) St. Patric	ks Drive	, Suit 4	04, Wal	dorf, Mar	ryland	20603	
	Sta		31. Date filed (Month, Day, Year)  FFR 1 4	32. Registrar's Sig	nature /	backer					
	Registr	ell.	T T T T T	LUUU BERNELLE	100	Charles .					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend item 2 per dvr 9853 3-1-06 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 3. Time of Death Month **Physician** 23, -2005Rita Frances Dignan 4:09 P.M. February /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick St. Vincent Care Center Emmitsburg If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2⊠ F Deys Hours 90<sup>Yrs.</sup> Months Director 215-54-3359 June 11, 1915 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martial Hygiene. Important: if Nem 27 is marked other than "natural", or ferms 28 or 28s-f show any injury or other traumatic event, the Maddell Examinar maint be notified at 10a Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 1√2 Yes 2 No Director Emmitsburg Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 335 S. Seton Avenue Funerai 21727 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Religious Community Elementary/Secondary (0-12) College (1-4or 5+) Daughters of Charity Coilege 5+ Teacher 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary E. Bowling Joseph M. Dignan 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 333 S. Seton Avenue, Emmitsburg, MD 21727 Sister Camilla Harant 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) ST. JOSEPH'S P.H. 2/25/06 EMMITSBURG, MD. 22. Name end Address of Fecility 21. Signefure of Funeral Service Licensee SKILES FUNERAL HOME YOA 210 W. MAIN ST., EMMITSBURG, MD. 21727 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ensio Physician/Medical Due to (or as e consequence of): signed by the a td be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No þ 24b. Were eutopsy findings available prior to completion of cause of deeth? been si shoufd 24a. Wes an autopsy performed? Completed cartificata has b lirector, paga 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No ector: After this cartificator, by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA P 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 Could not be determined within 24 hours after dea To the Funeral Director complataly filled in by th 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier To the 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 24, 2006 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ALAN CARROLL, M.D. 310 S. SETON AVE. EMMITSBURG, MD. 21727 31. Dete filed (Month, Day, Year) 32. Régistrer's Signature State Registrar Û

DHMH 16 Rev 6/95

ORIGINAL

			1 - State of Maryland State of Maryland		artment of H			iene og. No. 006	06124
	Physici	an	Decedent's Name (First, Middle, Last)				Date of Deat     Month	Day Year	3. Time of Death
	/Medic		Bobbie Carl Dixon				Februa		
4	Examin	er	4a. Facility Name (If not institution, give street and number)	L . 7	Takoma	Location of Death		4c. County of Death Montgom	
	<b>-</b>		Washington Adventist Hospi  5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	O Bisth	
	Funeral Director		227-50-2137 x 20F 68	Yrs.	Months Days	Hours Min.	July 1	1,1937 V	place (State or Foreign Intry)
	P .		Usual Residence of Decedent	Y					10d Inside City Limits
	show	7	10a. State   10b. County   10c. City,	dove					10d. Inside City Limits  1√2 Yes 2 ☐ No
	the M	Director	10e. Street and Number	10 v e.	10f. Zip Code	<u></u>	1	Og. Citizen of What Cou	
	Mith Ba or	Dir	6513 Landover Road		20785			U.S.A.	, .
	death ms 2:	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of H	ispanic Origin? (Spe	city Yes or No-	14. Race - Amer	
ဖွ	or its		Armed Forces?  1 Never Married 2 Married 1 Yes, Give	1	ir Yes, specify Cuba 1 ☐ Yes 2 ☐ No	n, Mexican, Puerto  Specify:	nican, etc.)	Black, White	
21215-0036	72 hours after death with the Maryland "neturel", or itams 23a or 28a-f show clical Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates:				1	Specify:Bla	
5	c * 38	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of worki	ng	16b. Kind of Business/lo	ndustry
12	e filed within Il Hygiene. other than "	omp	Elementary/Secondary (0-12) College (1-4or 5+)			spector	9	stone Indu	ıstry
	Hygothe othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I	Maiden Sumame)	
lar		To	Huler Dixon			Etta Co	leman		
Maryland	2 short and is mu	0.3	19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zi	
	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		Tyrone Dixon/Son  20a. Method of Disposition 20b. Place	5812 se of Dispo	Jeffer	son_Heic	hts Ca	pitol Hei	ghts Md
Baltimore,	00-		N Burial 2 ☐ Cremation 3 ☐ Removal from State	netery, crei	natory or other place et Cem.	امه		Wash, D.C	
틆	permit. Pag Department importent: i any injury o		' 4 □ Donation 5 □ Other (Specify)  21. Signatur of runeral Service Licensee	22	2. Name and Addre	ss of Facility	-		
Ba	Dep imp		Must C Inderen	Dı	unn & Sc	ons 5635	Eads	st, N.E. 20	019
			23a. Part . Enter the disease, or complications that caused the death, shock or heart failure. List only one cause on each line.						Approximate Interval Between
J.	Enysician:		Immediate Cause (Final disease or condition a Sepsis						Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a conseque	nce of):					
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	ted nsit	nine	Cause (Disease or injury		1 Digon				
Ć,	execu n and ial-tra	Exar	that initiated events resulting in death) Last C. FIIG SLACE  Due to (or as a conseque		I Disea	se			
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medical Examiner	d						
9	ntifica ng ph	Medi	IF FEMALE:						
Вох	eath certific attending pl	lan/	23b. Was decedent pregnant 1 Live birth 2 Fetal d	eath 3[	Ectopic pregnancy			23d. Date of deliver Month	very Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of dea	th 5	Other (specify)				,
P.0	res that the de igned by the a be detached i		Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Vital Records,	uires sign ild be	d by	Hypercholesterolemia				1 🗆 Ye	es 2 No 3 Pro	bably X Unknown
00	s been s shoul	Completed					24a. Was a	n 24b. Were aut	opsy findings available
Re	о <u>г</u> о	mo					autops perform		ompletion of cause of
ital	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death			
of <	Physicien: this certific ral director,	To	1 Yes 2 No Hospital: 1 Inpatient 2 El	NOutpatier		4 🗀 Nul Sing Ho		ence 6 Other (Spec	ify)
	ding P. th. After t	ion:	1 X Natural 5 □ Pending (Month, Day Year)	8b. Time o Injury	Wor	yat k? Yes 2 ∐No	28d. Describe ho	ow injury occurred	
Division	ea or the	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hom	e. farm. st			28f. Location (SI	treet and Number or Ru	ral Route Number,
Div		Certification:	4 Homicide determined building, etc. (Specify)	,			City or Town	n, State)	
	To the Hospitel or A within 24 hours after To the Funerei Dire completely filled in by		29a. Certifier (Check only 21 Medical Examiner: On the basis of examination	edge, deat	h occurred at the tir	me, date and place,	and due to the c	ause(s) and manner as	stated.
	To the Hi within 24 To the Fu	edical	one) and manner stated.	n and/or in					
	With To To	Σ	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Month	
	2		> Elwer fruit		429	J 0	l F	ebruary 1	4 2000
1	(5)		30. Name and address of person who completed cause of death (Item 2	7-rn		Joak	on DC :	20020	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	re		Vashingt	on DC	20020	
	Regist		FFR 1 5 2006 Person M.	her	E .				

DHMH 17 Rev 1/2001

ORIGINAL

Nathan Duncan 06-01185 dl

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Southern Mary Land Hospital  Southern Mary Land Land Hospital  Southern Mary Land Hospital  Southern Ma		1 - State Registrar	"' State of Marytan		tificate of L		R	Reg. No.	U6125
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So Seed Boothin Number   Seed   7.496 (by 1.50 and broader)   Titlory 1 (by 1.00 by 1.	aminer					Location of Death			
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Table State		577-92-5262	453 M OFF				(Month Day	(Year) Co	
MD PRINCE GEORGE'S LAUREL  101.2p-Code  9.657 MUTKK ROAD  9.657 MUTKK ROAD  102.2p-Code  103.2p-Code  103.2p-Code  103.2p-Code  104.2p-Code  105.2p-Code  105.2p-			10c. Cib	v. Town or Lo	cation				10d. Inside City Limits
11. Marial Statistics   12. West Decedent (Even in U.S.   13. West Decedent of Heaping Chirgh? (Security 17st or No.   14. Read-American Indian.   12. West Decedent (Even in U.S.   13. West Decedent of Heaping Chirgh? (Security 17st or No.   12. West Decedent (Even in U.S.	ō		CEORCEIC	A LID ET					-
11. Marial Status   12. Was Decedent of Hispanic Origin? (Security Year or No 12. Was Decedent of Hispanic Origin? (Security Year or No 12. Was Decedent of Hispanic Origin? (Security Year or No 12. Was Decedent of Hispanic Origin? (Security Year or No 12. Was Decedent of Hispanic Origin? (Security Year or No 12. Was Decedent of Hispanic Origin? (Security Year or No 12. Was Decedent of Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent or Hispanic Origin? (Security Year or No 12. Was Decedent Origin? (Security Year Origin)	ec c		GEORGE 5 LA	AUKEL	10f. Zip Code			10g. Citizen of What Co	puntry?
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Specify Discounts   Specify Black   Specify	ner		12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	
16. Decedent's Dissail Cocception (Speech) only hymest grade completed (Give Note of york shored auring most of working (Give Note) of hymest grade completed (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note) of york shored auring most of working (Give Note)		1 Never Married 2 Married	1 ☐ Yes 2 No				nican, etc.)		
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Table   Name   Print   Mode, Ascale   Sumame	mp		College (1-4or 5+)	iire. L		7)		PRIVATE	
BATES    Page   Internation   Summaria   Sum			t)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
198. Informatis Name/Relationship (Type, Print)   198. Mailing Address (Street and Visioner or Rural Route Number, City or Town, State, 250 Code)	o Be	·			ì				
20s. Mathod of Disposition   1   20s. Including a Commonweal from State   20s. Deceation - City or Town, State   21   21   21   22   23   2006   23   23   24   2006   24   24   24   2006   24   24   24   24   25   25   25   25	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street a	and Number or Rur	al Route Numbe	r, City or Town, State, 2	Zip Code)
Separation   Common		MILDRED DUNCAN	LIBRI	9657	MUIRK RO	OAD LAURE	L, MARYI	LAND 20708	
Sapertification   Sapertific		'	20b. P	face of Dispo	sition (Name of	(e)	Date	20c. Location - City or	Town, State
Sapertic Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.			Themovariion State			0/00	/2006	LANDOVER, M	ARYLAND
Sapertic Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.     Approximate Intereval Between Oriset and Death Interesting in Original Between Oriset and Death Interesting in Original Between Original Between Oriset and Death Interesting in Interest		21. Signature of Fundy Service Li	maso .				B. JEN	KINS FUNERA	I. HOME
Sequentially list conditions, any resulting in death)    FFEMALE		1	$\rightarrow$	7	474 LANDO	VER ROAD	LANDOVE	R, MARYLAND	20785
Sequentially list conditions:    Sequentially list conditions:		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.  a. Chronic obstruction	ctive pu			or respiratory arr	est,	Interval Between
Due to (or as a consequence of):    FEMALE:   23c. If yes, outcome of pregnancy   1	niner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	bbus to (Sr as a consequ	uonea of).					
FEMALE   23d. Date of delivery   Month   Day   Year	sal Exar	that initiated events resulting in death) Last	C Due to (or as a consequent	uence of):					
Hepatic Steatosis: mild atherosclerotic cardiovascular disease    All									
Hepatic Steatosis: mild atherosclerotic cardiovascular disease   1   Yes 2   No 3   Probably 4   Minknown	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3					•
25. Was case referred to medical examiner?    1   2   2   No		Part II. Other significant conditions	contributing to death but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
25. Was case referred to medical examiner?    Comparison    d b	Hepatic Steatosis: m	ild atherosclerotic	cardio	vascular di	sease	1 🗆 Y	es 2□No 3□Pr	obably 4 Donknown	
25. Was case referred to medical examiner?    1	ete						24a. Wasa	an 24h Were au	itonsy findings available
25. Was case referred to medical examiner?   1	Ę						autops	sy prior to med? death?	completion of cause of
examiner?    To be a continuous process of person who completed cause of death (Item 23a) (Type, Print)   Part   Penn Street, Baltimore, Maryland 21201   Penn Street, Baltimore, Maryland 21201   Penn Street, Baltimore, Maryland 21201		25. Was case referred to medical				26 Place of Deet			2∐ No
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 1 Yes 2 No  28c. Injury at Work? 1 Yes 2 No  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier 29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  CME  29d. Date signed (Month, Day, Year)	0	examiner?	Hospital:	ER/Outnaties	t 3 DOA Othe				cify)
29a. Certifier (Check orly one)  29b. Signature and title of certifier  29b. Signature and daddress of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  February 16, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUBIO, MO  111 Penn Street, Baltimore, Maryland 21201	-	27. Manner of Death 1    Natural 5   Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Worl	/ at k?			ony/
29a. Certifier (Check ority one)  29a. Certifier (Check ority one)  29b. Signature and title of certifier  29b. Signature and due to the cause (s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  Permany 16, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUBIO MO  111 Penn Street, Baltimore, Maryland 21201	Sertific	datamina	289. Place of injury - At no	ome, farm, stre	eet, factory, office				ural Route Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  February 16, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUBIO, MO  111 Penn Street, Baltimore, Maryland 21201	edicai	(Check only 2 Medical Exa	miner: On the basis of examina	wledge, death tion and/or inv	n occurred at the time restigation, in my of	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner as date and place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)  ANA RUBIO, MO 111 Penn Street, Baltimore, Maryland 21201	Ž	29b. Signature and title of certifier	,		29c. License	e number			
ANA RUBIO, MO 111 Penn Street, Baltimore, Maryland 21201		> Chief			OCME		I	February 16	, 2006
		A	4.4.	23a) (Type,		C+ · ·	D-1	34 - 7	1 01 001
31. Date filed (Month, Day, Year)					III Penn	Street,	Balt1mor	ce, Marylan	a 21201

Registrar
DHMH 17 Rev 1/2001

FEB 2 3 2006

		•	1 - State Registrar	of Maryland		rtment of tificate of		_	giene Reg. No. 200	6 06126
i	Physicia /Medic		Decedent's Name (First, Middle, Last)	ozyhoff				2. Date of De Month	y 9,200	
<u>)                                    </u>	Examin Funeral		4a. Facility Name (If not institution, give street and	7. Age (In yrs. I	ast birthday)			8. Date of Bir		f Death  3 YO\\  9. Birthplace (State or Foreign Country)
Ļ	Director		219_44-6895 Usual Residence of Decedent	30	Yrs.		, , , , , , , , , , , , , , , , , , , ,	Apr 24		Pennsylvania
	deeth with the Maryland me 23a or 28a-f show r must be notified at	ctor	Maryland Carroll	10c. City	, Town or Lo	cation	Westmins	ter		10d. Inside City Limits 1 □ Yes 2 □ No
	th with th	ai Dire	10 East Green Street			10f. Zip Code	21157		10g. Citizen of Wh	nat Country? JSA
2-0030	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  By Injury or other traumatic event, the Medical Examinar must be notified at ODGs.	by Funeral Director	1 Never Married 2 Married 1 Yes.	Decedent Ever in U.S 1 Forces? es 2 No , Give or Dates:		Vas Decedent of f Yes, specify Cu I ☐ Yes 2 ★ No	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No to Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. white
0-61212	d within 72 ho giene. ir then "netui ire Medicel	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	ed) ge (1-4or 5+) 2	(Give life. L	lent's Usual Occu kind of work done DO NOT use retin	e during most of wo red)	orking	16b. Kind of Bus  Alarm C	
/iand /	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)  Guy William Dayhoff	Б					, Maiden Sumame, leen Rock	
Mary	nd 2 shoulth and M		19a. Informant's Name/Relationship (Type, Print)  June M. Dayhoff, wife			•			er, City or Town, S nster, MI	
nore,	eges 1 au ant of Hea ant: If Item y or othe	1	20a. Method of Disposition  1 Burial 2 Fermation 3 Removal fr  4 Donation 5 Other (Specify)	om State	emetery, cren	sition (Name of natory or other pl roll Cre		Date 2/10 2006	20c. Location - C	city or Town, State
Бапт	permit. F Departme Importen any Injur		21. Signature of Funeral Service Licensee	M01191	22	. Name and Add	ress of Facility	Myers-Du		neral Home
ì	Physician /Medical		23a. Part . Enter the disease, or complications the sheck, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line.	Do not ente		ving, such as cardia			Approximate Interval Between Onset and Death ZasyS
,007	Ité be executed EX XI Sicien and III	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o to (or as a consequent to (or a consequent	uence of):					
ROX	the death certifica by the attending ph ached for use as th	Physician/Med	230. Was decedent pregnant 1 Link in the past 12 months? 4 Pr	, outcome of pregna ve birth 2 □ Fetal regnant at time of de nknown	death 3	Ectopic pregnan Other (specify)	су		23d. Date Mont	
as, r	w requires that the death been signed by the atte should be detached for	þ	Part II. Other significant conditions contributing to	to death but not resu	ulting in the u	nderlying cause g	jiven in Part I.			oute to the cause of death?
Hecor	The lay	Completed	J					24a. Was auto perfo	psy promed2 de	ere autopsy findings available for to completion of cause of lath?  Yes 2 \sum No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1	Inpatient 2	ER/Outpatien	it 3□ DOA C	ther	eath (Check only only only only only only only only	one) dence 6 ⊟Other	(Specify)
sion of	Ing Ing	cation: T	27. Many r of Death 1 Natural 5 Pending 2 Accident Investigation	ate of Injury Month, Day Year)	28b. Time of Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe	how infury occurre	d
DIVIS	ne Hospitel or Attendi 124 hours after death. Ne Funerel Director: A pletely filled in by the fr	Certific	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At ho uilding, etc. (Specify	me, farm, str	eet, factory, office	9	28f. Location ( City or To	Street and Number wn, State)	r or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	edicai	29a. Certifier (Check only one)  1	o the best of my knowned basis of examinat manner stated.	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the To the Comp	W	29b. Signature and title of certifier	rel me			nse number	3	29d. Date signed	(Month, Day, Year)
	CRW		30. Name and address of person who completed of	cause of death (Item	23a) (Type,		507 ve	Sminer	- MO	21157
	Sta Registi			2. Redistrar's Signa	ture	frede	-	1 1. 91	1000	

			For State Registrer	Sta	ite of Ma	ryland / De	epartmen Certificat			and M		Reg. No	Ullh	061	27
	Physicia	an	Decedent's Name (First, Mid	dle, Last)	. )					İ	2. Date of De Month	ath Da		3. Time o	- 11
	/Medic Examin		4a. Fecility Name (If not institut	on, give street a	and number)	r	4b. City,	Town, or	Location (	of Death		40	. County of Dear		· -
		<u>.</u>	Habran	moth			(day) If Under	عبار	If Under	24 Hrs	o Data of Bi	20	2000	man	as Familia
	Funeral Director		5. Social Security Number 126-14-9829	6. Sex 1 M 2		(In yrs. last birth	Months	Days	Hours	Min.	8. Date of Bir (Month, Da May 12,	1901	l Pol	thplace (State ountry) Land	or Poreign
			Usual Residence of Decedent 10a. State 10b. Cour	h		10c. City, Town	or Location							10d. Inside C	City Limits
	Marylan -1 show	ō		gomery		Potom									2 No
	th the	Funeral Director	10e. Street and Number				10f. Zip						tizen of What Co		
	sath w	eral	11817 Rosalind		as Decedent E	ever in U.S.		0854	ispanic Ori	ain? (Sp	ecify Yes or No		ted Sta		
920	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show te Mdical Exertiret must be mulified at	þ	11. Marital Status  1 □ Never Married 2 □ M  3 ◯ Widowed 4 □ Divorce	arried 1	med Forces?  Yes 2X N Yes, Give har or Dates:	1	If Yes, spe 1 ☐ Yes		Specify:		ecify Yes or No Rican, etc.)		Black, Whit	White	
Maryland 21215-0036	"natur	Completed	15. Deced (Specify only high	ent's Education nest grade comp	oleted)	16a. E	Decedent's Usu Give kind of wo life. DO NOT u	al Occup ork-done	ation du <i>ring m</i> os	t of work	ing	16b. K	(ind of Business	/Industry	
212	withir jiene r then	omp	Elementary/Secondary (0-12	) Co	ollege (1-4or 5-	+}	eption		·			pri	vate		
nd	be filed within 73 ital Hygiene. id other then "n. event, it. e M. al.	0	17. Father's Name (First, Middle Isaac Meyer	e, Last) Frucht	man				18. Mothe Toba	er's Name	e (First, Middle		Sumame) Eichler		
ryla	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, It e M.	ဥ	19a. Informant's Name/Relation			19b.	Mailing Addres	s (Street		er or Run	al Route Numb		or Town, State,	Zip Code)	
	and 2 salth ar 127 is er treu		Hellaine D. Ne										ryland		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury of other treumatic es	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation		al from State	20b. Place of I cemetery					Date		ocation - City or		
Ħ	artimen prient: Pa		* 4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Servi			ML. NE	bron Co					-	eens, Ne Home, PA		
Ba	Depril		Dowld U,	Barge	wards		4400 I	Powde	er Mi	11 R	oad Bel	tsvi	iome, PA 11e, Ma	ryland;	20705
68760,	Physician and busician and street be executed by sician and street stree	edical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter binder tying Cause (Disease or injury that initiated events resulting in death) Last	ab	Due to (or as a	a consequence of a cons	f):							Interval Be Onset and	tween Death
P.O. Box (	To the Hospital or Attending Physicien: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buran	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1[ 4[	yes, outcome □Live birth □Pregnant at □Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s		y				23d. Date of de Month	olivery Day	Year
ls, P	res that signed b	by Pl	Part II. Other significant cond	-	ing to death bu		the underlying	cause giv	en in Part	l.		tobacco Yes 2	use contribute t	o the cause of robably 4	
Vital Records,	w requi	Completed	13/5/2000		261136	>					24a. Wa		24b. Were a	utopsy findings completion of	s available
Re	The lar	omp	0000	- mile		*	-					opsy formed?	death?	s 2 No	cause or
/ital	cien: ertifica ector, p	Be	25. Was case referred to examiner?	ical Hospita	al.			Oth	and the second		th Check onl				
of	Physi or this o	2	1 Yes 2 No 27. Manner of Death		a. Date of Injui (Month, Da)		ime of	28c. Inju	ry at	ursing Ho	ome 5 ☐ Res 28d. Describe		6 □Other (Speury occurred	ecity)	
ion	anding rath. or: Afte	ation	Z /tooldont	estigation	(Month, Da)	y rear) III	jury M		Yes 2	]No					
Division of	or Atter de Directe in by ti	Certification:		ald not be ermined 28	e. Place of Inju- building, etc	ury - At home, far c. <i>(Specify)</i>	m, street, facto	ry, office			City or To	(Street a	and Number or R te)	iurai Houte Nu	mber,
	re Hospital or 124 hours afte te Funerel Dir tetely filled in	edical Ce	29a. Certifier Certi (Check only one)	cal Exeminer: (	n: To the best On the basis of and manner sta	of my knowledge f examination and ated.	death occure	d at the ti	me, date a opinion, de	nd place, ath occur	and due to the red at the time	e cause(: ), date ar	s) and manner a nd place, and du	s stated.	(s)
	To the within 2 To the comple	Me	29b. Signature and title of cer	tifier			2	9c. Licens	se number			29d. D	ate signed (Mon	th, Day, Year)	
	3		P9-3	224	tod on 102 = 1	looth (Itom 23a) (		SUUC.		84		ン	1.5/50	, C	
			30. Name and address of personal control of the con	son wno comple	Deriver Cause of G			211	V. vil		( mg	34.	0852		
	St Regist	ate rar	31. Date filed (Month, Day, Yo		32, Registr	ar's Signature	parte								

			i lease	State of Marylan		t of Health and I		
			1 - State Registrar	Olaro or marylan		e of Death		g. No. 006 06 28
0	₹	4	1. Decedent's Name (First, Middle, L	ast)			2. Date of Death	3. Time of Death
	Physici /Medi		NATHAN	WILSON	DOYE		FEBRUARY	Day Year 1016 M
	Examir		4a. Facility Name (If not institution, gr	4	1	Town, or Location of Death	1	4c. County of Death
		10/22	SHADY GRE			R SCICVICATION OF THE PROPERTY		MONTGOMERY
	Funeral Director		5. Social Security Number 6.  218-16-0438  Usual Residence of Decedent	Sex   7. Age (In yrs.	Yrs. Months	Days Hours Min.	8. Date of Birth (Month, Day, Nov 21	
	/land		10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limits
	Man-fa-fa-fa-fa-fa-fa-fa-fa-fa-fa-fa-fa-fa-	ţċ	Md Montgo	omery G	aithersbu	ırg		1 X Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip		10	g. Citizen of What Country?
	s 23a	ra		dal Court,		877		U.S.A.
	Item Iner	Funeral	11. Marital Status 1 □ Never Married 35 Married	12. Was Decedent Ever in U. Amed Forces? 1 ☐ Yes 2 ☑ No	If Yes, spec	dent of Hispanic Origin? (S) cify Cuban, Mexican, Puert	Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	72 hours after death with the Marylan natural', or Items 23a or 28a-1 show areal Examiliar must be collised at		3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2/21/40 Specify:		Specify: Black
21215-0036	72 hours after death with the Maryland naturel', or Items 23s or 28s-f show dical Examiner must be portified at	Completed by	15. Decedent's E (Specify only highest g.		16a. Decedent's Usua	al Occupation	kina 1	6b. Kind of Business/Industry
121	within liene.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		rk done during most of work se retired) .nce Worker		Montg. County
	filed Hygi ther int,		8th Grade  17. Father's Name (First, Middle, Las	et)	Maintena		ne (First, Middle, M	Public Schools
an		To Be	James Doye	7		Grac		
Maryland	es p E E	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address			City or Town, State, Zip Code)
	1 and 2 Health a tem 27 ls		Doris I. Do		and the second s		Gaither	sburg, Md #20877
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		lace of Disposition (Namemetery, crematory or of	me of ther place)		0c. Location - City or Town, Slate
Baltimore,			4 ☐ Donation *5 ☐ Other (Spec	ity) Me	tro Crema	tory 2/1	7/06 A	lexandria, Va
Ba	permit. Departr Importa sny Inji	1	Signature of Pulleral Service Cities	The second	A Snowd	en Funeral	Home P	.A. 20850
			23a. Part1. Enter the disease, or cor shock, or heart failure. List ont	nblications that caused the death	h. Do not enter the mod	. Washingt e of dying, such as cardiac	on St, or respiratory arre	Rockville, Md st, Approximate
	Physician		Immediate Cause (Final disease or condition	a. ANTERIOR				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	uence of):	771 4301772	-11010	4 hours
	Examiner	١,	Sequentially list conditions,	b. Due to for so a consequent	100 co of)			
	rted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence or):			
Ć,	be executed sicien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):			
1760,	a × a	cal	•	d				
68 ×	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Med	IF FEMALE:					1
Box	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	Ideath 3 ☐ Ectopic pre			23d. Date of delivery  Month Day Year
0	at the de by the a tached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of de 9⊡ Unknown	eath 5 ☐ Other (sp	өсту)		
<u>α</u>	s that ned b	by Pt	Part II. Other significant conditions	contributing to death but not resi	ulting in the underlying ca	ause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Vital Records,	w requires been sign should be		Congestive	HEART FAU	lure		1 ☐ Yes	2 No 3 Probably 4 €Unknown
eco	e law requ has been ge 2 shoul	piet					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
= =		Completed					perform	ed? death? ▼No 1 Yes 2 No
Vita	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Other	th (Check only one	
<del>o</del>		2:10	1 Yes 2 PNo 27. Manner of Death	1 ✓ npatient 2 ☐	ER/Outpatient 3 DO 28b. Time of	A Hursing III	ome 5 Resider	ce 6 Other (Specify)
ion	Attending I r death. ector: After by the funer	atior	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	8c. Injury at Work? 1 Yes 2 No		,
Division of	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not determined		ome, farm, street, factory	, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	Hospital or A 4 hours after Funeral Dire tely filled in by							
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2   Medical Exa		tion and/or investigation,	, in my opinion, death occur	red at the time, dat	e and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of confiler		290	. License number	29	d. Date signed (Month, Day, Year)
)	8		1 John	no	D	126443	Fe	bruary 10, 2006
	U		30. Name an la resul person who	completed cause of death (Item	23a) (Type, Print) GA	regory H. 1	FISHER	
200	Sta	to.	31. Date filed (Month, Dav. Year)	STOVE KONA	KOCKVI,	11e, MARYLI	TNOC, 20	0850
	Registr	ar	FEB 14	2006 Januar A	4. Apontal			d. Date signed (Month, Day, Year)  BRUARY 10, 2006  0850

DHMH 17 Rev 1/2001

State Registrar

				State of Maryl		irtment of F <i>tificate of</i>			ene g. No.	5	06130	
	· · ·		1. Decedent's Name (First, Middle, Las	t)				2. Dete of Death Month		Year	3. Time of Death	
	Physici /Medic		Jack Thomas	Eichelberge	er			February	y 8 20	006 P	11:33AM	
1	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or L		4c. County		t 0 m	
			Beverly Health C		ure last hirthday)	If Under 1 Year	Hagersto	8. Date of Birth	wa	Shing Birthol		
	Funeral Director		219-/6-3//5	<sup>3</sup>	yrs. last birthday) Yrs.	Months Days	Hours Min.	Jan. 13	, 1933	Ma	ace (State or Foreign ry) ry land	
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or Lo	cation				10	d. Inside City Limits	3
	Maryl f sho	to	Maryland Washing	iton		Hage	rstown				1 ☐ Yes 2 🗷 No	)
	r 28e	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Count	ry?	
	h with	a D	750 Dual Hig	ihway			21740		U.S.	۹.		
20	72 hours after death with the Maryland neturel', or items 23a or 28e-f show dical Exantrect was be multiled at	y Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2★ No If Yes, Give		Vas Decedent of F f Yes, specify Cub □ Yes 2X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		e - America ck, White, e	etc.	
9	n 72 hours "neturel", edical Eva	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a Deced	lent's Usual Occup	pation	1	6b. Kind of Bu		hite	-
15	C * 38	plete	(Specify only highest grad		(Give	kind of work done OO NOT use retire	during most of work d)	king		2011100041110	uony	
212	filed within Hygiene. ther then "	mo:	Elementary/Secondary (0-12)	n		shoppi	ng ma	11				
nd	should be filed within 72 ho nd Mental Hygiene. marked other then "netur imatic event, tre Medical	Bec	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		10)					
yla		2	Emmett A. Eiche				l	ence Cla		01-1- 7	0- (-)	_
Mar	0 8 8 8	1	19a. Informant's Name/Relationship (7) Robert Eichelberge	• •		•	and Number or Rui	rai Houte Number, Srunswick	-	_	Code)	
e,	5 20 2		20a. Method of Disposition		b. Place of Dispo	sition (Name of			0c. Location -		vn, State	_
Baltimore, Maryland 21215-0020	pemit. Pages 1 a Department of He Important: If item eny Injury or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			natory or other pla Cemeter		2/10/06	Woods	boro,	MD	
alti	mit. I partm portar y Inju		21. Signature of Funeral Service Licens			. Name and Addre		rtzler F	uneral	Home		
Ω	8858		Catharine (	) Xarlle	4	04 S. Ma	in St.	Woodsbor	o, MD	21798		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	or respiratory arres	st,		Approximate Interval Between Onset and Death					
Physician   Medical   Immediate Cause (Final CMF) NIC   NIC   OCC.												
	Examiner		disease or condition resulting in death)	a. Due 1	to (or as a conseq	uence of):	28420					
	p #	iner	_	& hron	ie wi	ng orti	nizahi	m				
	ficate be executed physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		o (or as a conseq	uende of):	Q.					
68760,	sician buria		cause. Enter Underlying Cause (Disease or injury that initiated events	C	ncostn	ny				-		
687	E 00 66	edical	resulting in death) Last	Due to	o (or as a conseq	uence om;						
Вох	eath certif attending I for use a	N.	•	d						-		_
	death	slcia	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause giv	ven in Part I.	23b. Did tob	acco use col	ntribute to	the cause of death	?
P.0	The law requires that the death certiate has been signed by the attending page 2 should be detached for use a	/ Physician/M	Mamiellinra	sistant sl	aphyl	DWILL	e	1 □ Ye	s 2☑ No	3 🗆 Prob	ably 4 ☐ Unknow	'n
rds,	uires n sign	q p	auren & Dia	ulmmas	(000)			24a. Was an	autopsy	24b. We	re autopsy findings ilabla prior to	
of Vital Records,	aw require is been si 2 should I	Completed by		·	- COUPIN	gourn		perform	ea?	con	npletion of cause eath?	
Re	The la	E	Hyperenn	$\sim$				1□ Yes	2 No	1 🗆	Yes 2□ No	
ita		Be C	25. Was case referred to medical examiner?					th (Check only one	)			
× ×	9 9	P	1 ☐ Yes 2 ☐ No	-	2 🗆 ER/Outpatien	t 3LI DOA		ome 5 Resider			)	
D UC	iing P. J. After t	tion:	27. Manner of Death  J Natural 5 ☐ Pending  a ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wo	ryat rk? ∣Yes 2 □ No	28d. Describe how	v injury occuri	rea		
Division	To the Hospital or Attending Phwithin 24 hours after death.  To the Funerel Director: After thi completely filled in by the funeral	Certification:	2 Accident  3 Suicide  4 Homicide	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)		_	28f. Location (Stre City or Town,	eet and Numb State)	er or Rural	Route Number,	
Ω	pital o		29a. Certifier 1 Certifying Phy	rsiclan: To the best of my	knowledge death	occurred at the til	me, date and place	and due to the car	use(s) and ma	inner as sta	ated.	
	ne Hos n 24 hc ne Fun oletely	Medical	(Check only 2 Medical Exam	iner: On the basis of exan and manner stated.	nination and/or inv	estigation, in my	ppinion, death occur	red at the time, dat	te and place,	and due to	the cause(s)	
	To the within 2 To the comple	ž	29b. Signature and title of certifier			29c. Licens			d. Date signe	d (Month, E	Pay, Year)	
	WIL		( P P)			DO	06232-	7 2	18/	06		
	1		30. Name and address of person who o		(Item 23a) (Type,		1 (TO: 10	4. MO	2-1-	140		
	Sta	te	31. Date filed (Month, Day, Year)	368 MILL 32. Regi <b>r</b> rar's S			STOWN	עיו ויו		. 10		
1	Registr		FEB 1 3	2006 Magas	· K	South ,						

			1 - For Stata Registrar	State of Marylan	-	artment of F			jiene lag. No.	6 (	16131
į	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
	/Medic		Glenn Richard	Eckard				Februar		2006	12:21P M
	Examir	er	4a. Facility Name (If not institution, give stre			4b. City, Town, o	r Location of De tminste			ty of Death	1
	<u></u>		130 E. Green St.,  5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 F				ace (State or Foreign
	Funeral Director			<sup>2□</sup> F 71	Yrs.	Months Days		lin. 8. Date of Birth (Month, Day)	1935	Mar	y land
	pu »		Usual Residence of Decedent  10a. State 10b. County	100 6:1	. Taua aula						0.1
	shov	ក	10a. State 10b. County  Maryland Carrol		y, Town or Lo	estminste	a r			'	0d. Inside City Limits 1
	28a-f	ect	10e. Street and Number	<u> </u>		10f. Zip Code			l0g. Citizen o	f What Coun	to/?
	3a or	0	130 E. Green St.,	Apt. 1		2115	7		_	J.S.A.	,
	death	nera		Was Decedent Ever in U.	S. 13. \			(Specify Yes or No- lerto Rican, etc.)		ace - Americ	
9	or Ita	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give		1 Yes, specify Cuba 1 □ Yes 2 🛣 No	an, mexican, Pu Specify:	ieno Hican, etc.)	Spec	ack, White,	etc.
00	ural',	d b	3 Widowed 4 Divorced	Year or Dates:						, WI	ite
7	"nat	lete	15. Decedent's Educat (Specify only highest grade c	ompleted)	(Give	tent's Usual Occup kind of work done DO NOT use retired	during most of v	working	16b. Kind of	Business/Inc	dustry
212	y with	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5+)		equipme		ator	county	gove	rnment
פ	al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle,		ame)	
ylaı	Menta Menta arked	Tof	John Henry Eckard		,		Gra	ce Ruth Ma	ackley		
Mar	d 2 shoth and 7 is m		19a. Informant's Name/Relationship (Type, Barbara Eckard/ wif	·		g Address (Street		Rural Route Number			<sup>Соде)</sup> MD 21157
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any follury or other traumatic event, the Madical Examinating Landilliad at ADES.		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	- 1		20c. Location		
E	Page nent o int: If iry or		1 ☐ Burial 2 🖔 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	IOVALITOM STATA			, i	14/2006	Sykesy	/ille,	MD
att	permit. Departn Imports any Inju		21. Signature of Funeral Service Licensee	01/ 60	/ 22	. Name and Addre	ss of Facility H	artzler Fu	uneral	Home	
_	2011		Catharine C	- Vaille				Union Brid		2179	1
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one lamediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):		g, 500m as sairs	and of coping of the			Approximate Interval Between Onset and Death
58760,	Attending Physician: The law requires that the death certificate be executed or death.  •ctor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):						
P.O. Box 6	es that the death certific igned by the attending E be detached for use as	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)				ate of delive fonth	ry Day Year
	s that ned b s deta	by Pt	Part II. Other significant conditions contri	outing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?
rds	w require been sig should b	ed b						_ 1 □ Yo	es 2 No	3 Prob	ably 4 Unknown
Records,	sician: The law re certificate has ber irector, page 2 sho	Completed						24a. Was a autops perform	sy	. Were autor prior to con death? 1 \( \subseteq \text{Yes}	osy findings available inpletion of cause of
<u>=</u>	artifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of D	Death Check only on	-		
<u>&gt;</u>	hysic this co	၉	1 ☐ Yes 2 No Hos	pital: 1   Inpatient 2		t 3 DOA Oth	er: 4 Nursing	g Home 5 Reside			)
S S	After I	ion:	- Continue	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl	yat k? Yes 2 ∐No	28d. Describe ho	ow injury occu	ırred	
Division of Vital	Attence death octor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	ome, farm, stre		765 2 140	28f. Location (Si		ber or Rura	l Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page			building, etc. (Specify				City or Towi			
	Hosp 24 hou Fune etely fi	edical	29a. Certifier Certifying Physici (Check only one)	<ul> <li>an: To the best of my know</li> <li>On the basis of examinat and manner stated.</li> </ul>	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and pla pinion, death o	ace, and due to the concurred at the time, d	ause(s) and n ate and place	nanner as st , and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date sign	ed (Month, L	Day, Year)
}	WIR		> Zahran Keh	n mo		DS	873	36	2/10	106	
	W		30. Name and address of person who comp	leted cause of death (Item					-		157
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regintrar's Signa	ture				,		
400	negisti	(A)	I FD T 9 70	UU JUSTANIE	S	Society 5					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stata Ragistrar	State of M	aryland		artment of H		and M	-	jiene	06	06132
	Physicia	20	1. Decedent's Name (First, Middle, Last,	)						2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Paul J. Esbenser							Feb.	9,	2006	4:10 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or					nty of Death	rundel
			Anne Arundel Med 5. Social Security Number 6. Sec			ast birthday)	If Under 1 Year	apoli:		8. Date of Birth			
	Funeral Director			M 2□F	76	Yrs.	Months Days	Hours	Min.	(Month, Day,	, Year)	Co	nplace (State or Foreign untry)  NY
	P.		Usual Residence of Decedent								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	show	2	10a. State 10b. County Queen A	Anne's	10c. City	, Town or Lo	Stevens	<i>i</i> lle					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	rect	10e. Street and Number				10f. Zip Code			1	l0g. Citizen	of What Co	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f show the Wedical Exam incrinitation of	Funeral Director	407 Queens Court				216	566				USA	,
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Ori	gin? (Spe	cify Yes or No-		Race - Amer Black, White	ncan Indian,
36	or It	by Fu	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 🔯 If Yes, Give			1 ☐ Yes 2 ☑ No	Specify:	., , , , , , , , , , , , , , , , , , ,			cify: Wh	
Ö	hours tural	q pa	3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:		16a Dece	dent's Usual Occupa	ation	·				
7.	n "na	plet	(Specify only highest grad	e completed)	5.1	(Give	kind of work done a DO NOT use retired,	during most	t of workin	g	16b. Kind o	1 003111933/1	noustry
21215-0036	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or	3+)		Captair	า			M	ariti	me
pu	be file	Be	17. Father's Name (First, Middle, Last) Hans Jacob Esbens	sen						(First, Middle, I		name)	
Maryland	2 should be to and Mental I smarked o raumatic eve	은	19a. Informant's Name/Relationship (Ty			10h Mailir	ng Address (Street a					ım Stato 7	in Code)
	and 2 sauth an n 27 is ier trau		Lillian H. Esbens				Queens Co						
re,	s 1 ar		20a. Method of Disposition			ace of Dispo	sition (Name of matory or other place		Feb.		20c. Locatio		
Ē	Pages nent of ant: If its ary or o		1 ☐ Burial 2 【X Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)			06	Balti	more,	MD				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, "to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event," to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event, "to Medical Example to the traumatic event," to the traumatic event, "to Medical Example to the traumatic event, "to Medical Example to the trauma		21. Signature of Funeral Service Eigens	Zann	7	- E	Name and Address Barranco & 195 Gov. F	s Son Ritch	š, P. ie Hw	A. Seve	erna P erna P	ark F ark,	uneral Home MD 21146
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or				Approximate Interval Between						
	Pnysician	8 1	Immediate Cause (Final disease or condition resulting in death)	a		M	yocar le	41	1 uta	viten	_		Onser and Death
ø	/Medical Examiner			Due to (or as	a consequ	ience of):	r.						
	HC.	Jer	if any, leading to immediate	Due to (or as	a consequ	ence of):						_	
	ocuted nd transil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
8760,	cate be executed obysician and the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequ	ience of):			-				
687	death certificate be executed e attending physician and nd for use as the burial-transit	Physiclan/Medlcal		d									
Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			De				23d.	Date of deli	very
	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnancy Other (specify)					Month	Day Year
P.0	that the de led by the a detached t	Phys	9 Unknown							T			
	og og	by	Part II. Other significant conditions con	ntributing to death t	out not resu	ilting in the ui	nderlying cause give	en in Part I.		23e. Did tot	_		the cause of death?
Ö	w requir been si should	etec											
Records,	The tay ate has page 2:	Completed								24a. Was a autops perforr	ned?	prior to c death?	topsy findings available ompletion of cause of
		a	25. Was case referred to medical					26. Place	of Death	(Check only on	2) No	1 🗆 Yes	2 No
$\geq$	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 2 No	lospital: Inpati	ent 2 🗆 8	ER/Outpatien	nt 3 DOA Othe			ne 5 Reside		Other (Spec	ify)
0 0	tending Physician: leath. tor: After this certific the funeral director,		27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Inju	ury ay Year)	28b. Time of Injury		at		8d. Describe ho			
Sio	Attending r death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be					res 2 □ l					
Division of Vital	for Attendate death Director:	Certification:	4 Homicide determined		ijury - At hoi tc. <i>(Specity</i>		eet, factory, office		2	8f. Location (St City or Town		mber or Ru	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Cartifying Physics	sician: To the best	of my knov	wledge, death	h occurred at the tim	e, date an	d place, a	nd due to the ca	ause(s) and	manner as	stated.
	the Ho in 24 I the Fu	edical	(Check only 2 Medical Exami	ner: On the basis of and manner si	of examinati tated.	ion and/or in			th occurre	d at the time, d	ate and plac	e, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. License	number	2 /	2	9d. Date sig	ned (Month	, Day, Year)
,			1 dy y fru	well >	dent to	00-1 07	U)	7103	56		2/	7/3	006
			30 Name and address of person who co	ompleted cause of	10	23a) (Type.	Print) Dr	ive	Clei	Lu, MI)	216	19	
	Sta		31. Date filed (Month, Day, Year)	32. Pagist	rar's Signat	ure	1 4					-/-	
	Registr	ar	FEB 1 3 20	106	ر معد	5 A	2000						

DHMH 17 Rev 1/2001

		•	For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>		nt of H te of L		and M		giene Reg. No:	006	06133
	Dhomini		1. Decedent's Name (First, Middle, La	•							2. Date of De		Yeer	3. Time of Death
	Physici: /Medic			Bel1		F	ishm				Februa:			06:00AM <sup>M</sup>
Ì	Examin	er	4a. Facility Name (If not institution, given		ber)				Location o	of Death			County of Death	
			Gilchrist Cen 5. Social Security Number 6.3		7. Age (In yrs.	last hirthday)	Ba If Und	timo er 1 Year	re If Under :	24 Hrs.	8 Date of Bir		timore	
	Funeral Director			1 □ M 2XXF	77	Yrs.	Month		Hours	Min.	(Month, De	oer 1	5 1928°	place (State or Foreign intry) New York
	ט		Usuel Residence of Decedent											
	arylar show	_	10a. State 10b. County			ty, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ▼ No
	8a-f	Directo	Maryland Howard		Co	lumbia	404.7	. 0. 1-				10- 03	( ) 4 ()	
	d within 72 hours after death with the Maryland jene. Itahan "natural", or Itama 23a or 28a-f ehow Ita Medical Examinat must be notified at		10e. Street and Number 10,001 Windstr	eam Driv	e		10f. 2	ip Code	21044			-	en of What Co.	,
	ne 23	Funerai	11. Maritat Status	12 Was Dece	dent Ever in I	J.S. 13. V	Was Dec			gin? (Spe	cify Yes or No		4. Race - Amer	
0	riten riten	Fun	1 □ Never Married 2 □ Married	Armed For 1 ☐ Yes	<b>206</b> 7 2∰No			3737		, Puerto f	cify Yes or No Rican, etc.)	1	Black, White	, etc.
3	ral', o	by	2 Widowed 4 □ Divorced	If Yes, Give Year or Da			1 □ Yes	SER NO	Specify:				Specify: Cau	castan
ל	72 h natu	etec	15. Decedent's E (Specify only highest gr			16a. Dece (Give	dent's Us kind of v	ual Occupa	ation <i>luring</i> most )	t of workir	ng	16b. Kir	nd of Business/I	ndustry
9500-61212	within lene. then "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		make		)			Dom	estic	
-	i try	ပိ	17. Father's Name (First, Middle, Las	!)				_	18. Mothe	r's Name	(First, Middle	L		
yiand	id be lental ked o	To Be		Unknow	n				Rose	e			Unk	nown
Mary	permit. Pages 1 end 2 should by Department of Health and Menta important: if Item 27 ie marked any Injury or other traumatic evance.		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addre	ss (Street a	and Numbe	r or Rura	Route Numb	er, City or	Town, State, Z.	ip Code)
Σ.	end 2 ealth n 27 in		Melissa A. Benson	- Daught					rie D		akton,			
9	t of H if iter or oth		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 [	Removal from S		Place of Dispo	natory o	other plac		_	ate 2004		cation - City or T	
altimore,	t. Partmen		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	• ·	KI				1		4		ls Chur	ch, VA
g R	permit Depa impo any i		21. Signature of Furieral Service Lice	5, m	110 A	j	effe	rson	Fune	řal (	Chapel,	Inc.		
i			23a. Part1. Enter the disease, or conshock or heart failure. List only	nplications that ca	used the dea	th. Do not ent	er the m	de of dying	g, such as	cardiac o	respiratory a	LEXAI	ndria,	VA 22315 Approximate
	Physician		Immediate Cause (Final		-									Interval Between Onset and Death
j.	/Medical		disease or condition resulting in death)	a. Due to	or as a conse	quence of):	Pru	vnn	" 7					DAY
	Examiner		Sequentially list conditions	b										,
	יי ק	iner	Sequentially list conditions, if any, leading to mine field cause. Enter Underlying Cause (Disease or injury	Dua to (	or as a sonsec	(to ceneup			-					
	and and I-trans	Examin	that initiated events resulting in death) Last	c. Due to (	or as a conse	Tuence of):						_		
8/60,	be exicien burial	Icai E			57 us u 051150	4001100 01).								
789	eath certilicate be executed attending physicien and for use as the bunat-transit	D		d										
XOD	n cert	ian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		Tectonia	pregnancy				2	3d. Date of deliv	very
ם מ	death le atter ed for u	sicia	in the past 12 inonths? 1 ☐ Yes 2 € No		ant at time of		Other (						Month	Day Year
r Ö	that the led by the detache	Physic	9 ☐ Unknown \								1			
S,	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	ndəriyinç	cause give	en in Part I.			tobacco us Yes 2. [	V	the cause of death?
ecord	requires seen sign should be	eted											47	
	e las has je 2	Completed							-		24a. Was auto perfo	psy	prior to co	opsy findings available ompletion of cause of
Vital H		ပိ	25. Was case referred to medical						OC Disease	of Dooth	1 ☐ Yes	ormed? 200 No	1 🗆 Yes	2 No
	ysician: is certific director,	OB	examiner?	Hospital:	npatient 2	] ER/Outpatier	nt 3□ [	Othe					Other (Spec	in hospice
ס ר	두 두 등	n; T	27. Manner of Death	28a. Date o		28b. Time o		28c. Injury Work			8d. Describe			77 14-07
Š	ttending death.	atic	1 Natural 5 □ Pending 2 □ Accident investigation	on			M		Yes 2□	No				
DIVISION	or Att	Certification;	3 Suicide 6 Could not determined	286. Place	of Injury - At h ig, etc. <i>(Speci</i>	nome, farm, str ify)	eet, fact	ory, office		2	28f. Location ( City or To	Street and wn, State)	Number or Rui	ral Route Number,
_	pitei ous a eraf [	Ce	29a. Certifier Certifying P	hysician: To the	hest of my kn	owledge deat	h occurre	d at the tim	ne date an	d place, a	and due to the	Cause(s)	and manner as	hateta
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exa	miner: On the ba	sis of examin	ation and/or in	vestigati	on, in my o	pinion, dea	th occurre	ed at the time,	date and	ptace, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0			2	9c. License	number			29d. Date	signed (Month	, Day, Year)
)			> Alla	my	)			ps	8 50 5			tops	vary 1	2006
)	(8)		30. Name and address of person who	/	101 10	m 23a) (Type,	Print)	St	Kari	me	no:	2120	4	3 2006
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	Registr		FEB 1 4 200	16	Te A	ature	No.							

			1 - For State Registrar	State of Ma	aryland .		artment of F tificate of		Mental Hy	giene Reg. No.	06	06134
×	Physici	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic			Ferguson		-			Februa	ry 3, 2	2006	6:49 a M
	Examir	er	4a. Facility Name (If not institution, g		•			r Location of Dea	th		ity of Death	
		á.	Southern Mary 1a  5. Social Security Number 6.		L e (In yrs. last	hirthday	Clinto	n If Under 24 Hrs	8. Date of Bi	Prin	ce Geo	orges
n E	Funeral Director		261-50-4343	1 □ M 21X F	69	Yrs.	Months Days	Hours Min	(Month, D	av. Year)	Tallah	lace (State or Foreign try) lassee, F1.
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation				11	0d. Inside City Limits
	f sho	ō	D.C.		Wash	ingto	n					1 X Yes 2 □ No
	158 288-	Director	10e. Street and Number		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip Code			10g. Citizen o	f What Coun	trv?
	3a o		1338 R. Street	N W #116			2000	q		Unite	d Stat	es
	deati	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H		Specify Yes or No		ace - Americ	an Indian,
936	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural, or Iteme 23a or 28a-f show eumatic event. It e Mucical Examiner must be mailified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		No.		Tes, specify Cubi	Specity:	no Rican, etc.)		lack, White, o cify: B1ac	
5-0036	2 ho	ted	15. Decedent's	Education	1	6a. Deced	lent's Usual Occup	ation		16b. Kind of	Business/Inc	lustry
Maryland 21215	within 7 ne. ihen "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	j+)		kind of work done OO NOT use retired	during most of wo d)	orking			
2	Hygie ther t		17. Father's Name (First, Middle, Las	zt)		Вос	kkeeper	18 Mother's Na	me (First, Middle	Priv		
auc	ag la b	Be	Benjamin Wilso					Rebeco			ame)	
<u> </u>	should nd Men marke	J.	19a. Informant's Name/Relationship		1	19b. Mailin	g Address (Street				n State Zio	Code)
	s 1 and 2 should of Health and Men item 27 le marke other treumatic		Freddie L. Wils				R. Stree					20009
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		сете	e of Dispos etery, cren urrec	sition (Name of natory or other place ction	εθ) Feb.	Date 17,2006	20c. Location	•	
altin	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic		1	22						
80 —			JAK G.S	ye Moie	5						ngton;	D.C.20020
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	molications that caused y one cause on each lir	the death. [	Oo not ente	er the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
V.	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Q(	with	my	2 Cestle	ally	andle	20	le	1.
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of:		,				
6		e	Sequentially list conditions,	b. Due to (or as	1 to the	and,	Jon Je	V			<u> </u>	report
	uted Insit	ulu u	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00		00 017.						
o Î	execu an and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):						
98/80	ficate be executed physician and is the burial-transit	edical	•	d								
_	ertific ling p	Mec	IF FEMALE:									
ROX	death certif e ettending ed for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal dea	ath 3 🗌	Ectopic pregnancy	,		1	ate of delive Nonth	ry Day Year
л. О	0 0 0	Physician/M	1 Yes 2 160	4∏Pregnant at 9☐ Unknown	time or deatr	1 5	Other (specify)					
	res that igned b	by PI	Part II. Other significant conditions	contributing to death bu	ut not resultin	g in the un	derlying cause giv	en in Part I.	23e. Did 1	obacco use co	ntribute to the	e cause of death?
ğ	w require been sig should b	edt	Mend for	luce					1 🗆	Yes 2□No	3 🗌 Proba	ably 4 Blakhown
Vital Records,	law requires that the as been signed by th 2 should be detache	Completed	•						24a. Was	an 24b	. Were autop	sy findings available
ř	The ete h page	Com							perfo	rmed?	death?	
<u> </u>	Physician: rthis certifice ral director,	Be	25. Was case referred to medical examiner?		/				ath Check only	one)		
0	Physi this o	2	1 ☐ Yes 2 ☐ No	Hospital:		Outpatient		4 🗀 Nursing r	Home 5 ☐ Resi			)
	ding F. After funer	lon	27. Manner of Death 1 Death 5 □ Pending	28a. Date of Injur (Month, Day	Year) 281	b. Time of Injury	28c. Injur Wor M 1		28d. Describe	how injury occi	nued	
<u> </u>		Icat	2 Accident investigati 3 Suicide 6 Could not	be One Blace of Inju	Inv - At home	farm etre		Yes 2 No	28f Location /	Street and Nun	abor or Russl	Route Number,
DIVISION	after after Direct	Certification:	4 Homicide	building, etc	. (Specify)	, iaiii, stre	et, lactory, office		City or To	wn, State)	iber or mulai	noute Number,
	To the Hospitel or Attenwithin 24 hours after deal To the Funerel Director: ormpletely filled in by the	calC	29a. Certifier 1 Certifying F	hysician: To the best of	of my knowled	dge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s) and r	nanner as sta	ated.
	the H in 24 the F nplete	Aedical	one)	and manner sta	ited.	androrinv			urred at the time,			
	5 \$ C E	Σ	29b. Signature and title of cortific	1			29c. Licens			29d. Date sign		**
,	7			7/			504	17		Jebu	3	206
R	/(3)		30. Name and address of person with	o completed cause of de	eath (Item 23	a) (Type, I سندوا	rint)	4000	1907			
	Sta	te	31. Date filed (Month, Day, Year)	. Registra	ar's Signature		Speing B	MUZZ	102			
i j	Registr	_	FEB 1 6 200	6 Care	JE.	A TOP						

			1 - For State Registrar	State of M	Marylar		artmen rtificat					giene Reg. No.	)6 (	06135
	Physici	an	Decedent's Name (First, Middl	e, Last)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medi		Lona B.								Februai	cy 11,		9:43 a <sup>M</sup>
¥ _	Examir	ier	4a. Facility Name (If not institution				_		Location of	of Death			nty of Death	
	-28	100	Southern Mary			land birth days		into	n If Under:	24 Hrs	0.00-1		ice Ge	
*	Funeral Director		5. Social Security Number 229-30-2881	6. Sex 7 1 ☐ M 2X F	Age (In yrs. 77	last birthday) Yrs.	Months	Days	Hours	Min. S	8. Date of Bird (Month, Da ept. 22	y, Year) 1928	9. Birthp Cour Norf	place (State or Foreign of try).
	p ,		Usual Residence of Decedent  10a. State 10b. County			ty, Town or Lo								
	Aaryla F sho	ō	•	e Georges		uitlan								0d. Inside City Limits 1    Yes 2   No
	28a-	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Cour	ntry?
	3a o	O E	2312 Ewing Ave.	#13				2074	6			Unite	ed Sta	tes
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than *naturel', or Itema 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at ance.	by Funeral	11. Marital Status  1 Never Married 2 Marital Microsoft Married 2 Never Married 2 Never Married 3 Never Married 4 Divorced	12. Was Deceder Armed Force 1 Tyes 25	s? []No	1	Was Dece If Yes, spe	_			cify Yes or No Rican, etc.)		lace - Americ lack, White, cify: Bla	etc.
Baltimore, Maryland 21215-0036	hin 72 ho a. an *natur Maulcal	Completed		it's Education st grade completed)	or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa rk done d se retired,	ition luring most	t of workir	ng	16b. Kind of	Business/Ind	dustry
2	ygian ygian yer tha	Con		5+		Tea	cher							Schools
and	t be fill H od oth	To Be	17. Father's Name (First, Middle,								(First, Middle, 111iott	Maiden Sum	ame)	
Ž	should nd Me mark matic	Ţ	Noah Lawrence 19a. Informant's Name/Relations		· · · · · ·	19b. Mailir	na Address	(Street a			I Route Numbe	or City or Tox	m State Zin	(Code)
S	alth ar 27 is			e,Jr. / Bro	ther						olk, Va		504	
ore,	of He		20a. Method of Disposition  1 Deurial 2 Cremation	3 ₹ Bernoval from Sta		Place of Dispo cemetery, crer	sition (Nai natory or c	ne of ther place	9)	D	ate	20c. Locatio	n - City or To	own, State
Ē	tment tant:		4 ☐ Donation 5 ☐ Other (S	Specify)		lvary					,2006	Norfoll	k, Va.	
Ba	permit Depar Impor any in		21. Signature of Funeral Service	Licensee			2. Name ar 5538				Funera /Fores	l Home	s,Ma.A	20747
8760,	Physician /Medical Examiner phisician and phisician and the printing the printing of the phision and the phisi	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence as a consequence	juence of): juance of).		u a	uche	5m_	4			
O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as it	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	ıl death 3 ☐	Ectopic pi						Date of delive Month	ery Day Year
rds, P.	w requires that been signed b should be deta	ρ	Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying o	ause give	n in Part I.					ne cause of death? ably 4√∑Unknown
Division of Vital Records,		Completed									24a. Was autop perfor 1 \( \text{Yes} \)	rmed?	prior to cor death?	psy findings available inpletion of cause of 2 No
<b>=</b>	iciar certif recto	Be	25. Was case referred to medica examiner?	Hasaital:			_	Othe	e-		Check only o			
on of	iding Phys th. : After this funeral di	tlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pen 1 2 Accident investi	28a. Date of Ir (Month, L		28b. Time of Injury		8c. Injury Work	4 11 1400	2	ne 5 🗆 Resid			y)
Divisi	To the Hospitel or Attending Physician: With 24 hours after dear M. To the Funeral Director After this certifica completely filled in by the funeral director.	Certification;	3 Suicide 6 Could determ	not b 28e. Place of	Injury - At he etc. (Specif	ome, farm, str y)	eet, factory	, office		2	8f. Location (S City or Tow		mber or Rura	l Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the be Examiner: On the basis and manner	of examina	wledge, death	n occurred vestigation	at the tim, in my op	e, date and inion, deat	d place, a	nd due to the o	cause(s) and i	manner as st e, and due to	ated.  the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie			4	290	. License	- /			29d. Date sign	4.	Dey, Year)
				<b>*</b>		$\geq$		128	630	1		2-1	4.0	9
	(i 0)	13	30. Name and address of person  Jacques 200	o completed cause o	f death (Item			RIL	50	ite	213 C	linton	mel	20735
	Sta Registr		31. Date filed (Month, Day, Year)	da Dani	strar's Signa							,		

DHMH 17 Rev 1/2001

			State of Maryland / Dep	artment of Health and M		iene	06106		
		•	1 - State Registrar Ce	ertificate of Death		eg. No.UUD	00130		
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month 02	Day Year 05 2006	3. Time of Death		
	/Medic	al	Ralph Edward Fowble  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	02	4c. County of Death	9:30 A <sup>M</sup>		
	Examin	er	18719 Falls Rd.	Hampstead		Baltimo	re		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	The state of the s	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Foreign Country)			
	Director		217-46-1544		08/28	/1946 Mary	land		
	yland		10a. State 10b. County 10c. City, Town or I	ocation			Od. Inside City Limits		
	e Mar	Director	MD Baltimore Hampst				1 ☐ Yes 2 ☐ No		
	with th		10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Coul	ntry?		
	ne 23	Funerai	18719 Falls Rd.  11. Marital Status 12. Was Decedent Ever in U.S. 13	21074  Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Americ			
9	or Itan		Amed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White, Specify: Whi			
00	be filad within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or itame 23a or 23e-f show event, the Modical Exantral must be rediffed at	d by	3 Widowed 4 Divorced Year or Dates:		1				
21215-0036	in 72 in 72	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business/In	austry		
212	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Car	penter		Construct	ion		
Maryland	be file ital Hy id oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name					
<u> </u>	should ind Men marka umatic	P	Pleasant Irving Fowble  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	ling Address (Street and Number or Rura					
	and 2 s aalth an n 27 ie i			19 Falls Rd. Har					
ore,	of Has of Has fitem rotha		20a Method of Disposition 20b. Place of Disp			·			
ij	Pagas ment of I tent: If it		`4 □Donation 5 □Other (Specify) Greenmon		3/2006	Hampstead,	MD		
Baltimore,	permit. Pagas 1 and 2 should be filad within 72 hours after death with the Marylan Depirtment of Haalth and Mental Hygiene. Depirtment of Haalth and Mental Hygiene. Importent: If item 27 is marked other than "natural, or itame 23a or 28e-f show any injury or other treumatic event, the Medical Examinating must be retilled at once in your injury.		N 0 0 7 7 7	22. Name and Address of Facility El 34 South Main Stre	ine Fune et Hamps	eral Home stead, MD 21	.074		
	Late be exacuted which we burial-fransit he burial-fransit he burial-fransit he burial-fransit he burial-fransit he burial-fransit here.	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not explore shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	rechibs Type	-Myocos	Iral Insign	Manedate  Manedate  Manedate  Manedate  Manedate		
O. Box 68	The law raquires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	Physician/Medic		□Ectopic pregnancy □ Other (specify)		ery Day Year			
۵.	quires that n signad b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tot	A.			
Records,	ician: The law raquir certificate has been s rector, page 2 should	Completed	Diabera nephropathy		24a. Was a autops perform	sy prior to co	opsy findings available impletion of cause of		
Vital	Physician: this certificatal director,	Be	25. Was case referred to medical examiner?	26. Place of Deat					
of/	Physic rthis c ral dire	- T	1			ence 6 □Other (Special ow injury occurred	(y)		
lon	Attending r death. sctor: After by the fune	ation	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			ampstead, MD  ral Home lead, MD 21074  Approximate Interval Between Onset and Death Onset and		
Division	I or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	28f. Location (St City or Town	treet and Number or Run n, State)	al Route Number,			
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funarel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, definition on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurrence.	and due to the cared at the time, d	ause(s) and manner as s late and place, and due t	stated. o the cause(s)		
<b>.</b>	To the To the compl	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month,	Day, Year)		
7	40		30. Name and address of person who completed cause of death (Item 23a) (Typ	1)70223 e, Print)	110	×16/06	,		
_	王		Rebecca Goedeke Mi) 42	31 N. Wevels Tree	I Hem	psteal Mi	21624		
	Sta Registi		31. Date filed (Month, Day, Year)  FEB 0 9 2006  32 Registrar's Signature	nonte					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:18 PM Naomi Olive Frantz February 15, 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Garrett Memorial Hospital Oakland Garrett 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) (State April 14, 1919 Maryland If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🗹 F 86 Director 214-36-7035 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Garrett Friendsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 Church Lane, P.O. Box 344 21531 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2K No Specify: þ 3

Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Friend Anna DeWitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 524 Sand Spring Rd., Friendsville, MD Darrell Frantz/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Blooming Rose Cemetery Feb. 18, 2006 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) a massive cerebrol hemorrhage /Medical 2 hours Examiner Examiner The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? a theroscienatic 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown <u>م</u> 24b. Were autopsy findings available prior to completion of cause of death? cordiovosculor diseose 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 🖎 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 27. Mariner of Death 28b. Time of 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760 After this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Certification: Medical

1 Natural

2 Accident

4 🗌 Homicide

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

5 ☐ Pending investigation

6 ☐ Could not be determined

00025759 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 247. Accident MD21520 MD Noumann 2006 Registrar's Signature 31. Date filed (Month,

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** FEBRUARY WAYNE I. FOSTER 18,2006 8:55A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 20 TEAL COURT LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min XXM 2 F Yrs. 216-22-3091 78 Director OCT.12,1927 INDIANA Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location หลก 27 เร marked other than "naturel", or Itams 23a or 28e-1 show other traumatic evant, tre Mcdical Evar กามสาคา เการ์โก๊ะปลา 1√Xes 2 No Funeral Director MARYLAND CHARLES LA PLATA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20 TEAL COURT 20646 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after TX X'es 2 No If Yes, Give Year or Dates] 945-1946 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: by 3 Widowed 4 Divorced WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 MANAGEMENT ANALYST U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental Hient: If itam 27 Is marked other. CLYDE FOSTER RUTH LOVELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELAINE C. FOSTER-WIFE 20 TEAL COURT, LA PLATA, MARYLAND 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MARY ā permit. Page Department of Importent: If any injury or MARYLAND VETERANS CEM. 2-23-2006 CHELTENHAM, MI MO0479 22. Name and Address of Facility 21, Signature of Experal Service Licens RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tailu or cate RLAG Physician /Medical Due to (or as a consequence of): **Examiner** Mu It po le if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performad?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 10 5 △ esidence 6 ☐ Other (Specify) 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Malper of Death Certification: To tha Hospitel or Attanding 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0033426 2-20-2006 941 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature AUE. LAPLATA MI 111 CAGRANGE ARRY Garage State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 11 per inf 9853 3-8-16 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elruary WILLIAM GREGORY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months ₩ 2 D F 579-54-0090 62 08-14-1943 NORTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits PRINCE GEORGE LANDOVER 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2104 EAST MARLBORO AVE #13 20785 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 🏻 No BLACK Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\text{th} \end{array}$ College (1-4or 5+) LABORER PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) GEORGE GREGORY SHEARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES RUSTIN JR/FRIEND 2104 EAST MARLBORO AVE # 13 LANDOVER, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State RIVERDALE CREMATORY 02-14-2006 4 □ Donation 5 □ Other (Specify) RIVERDALE, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 0 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Pa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 Vo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X npatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

29c. License number

m0060611

Good Luck Road

29d. Date signed (Month, Day, Year)

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760. Division of Vital s after dec. within 24 hours a To the Funeral C

Physician

/Medical

Examiner

10a. State

MD

Director

by

Be Completed

Examine

Be Completed by Physician/Medical

Certification: To

Medical

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**Funeral** 

Director

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r than "natural", or Items 23a or 28a-f show

other than

permit. Pages 1 and 2 should be filit Department of Health and Mentar Hy, Important: If Item 27 is marked other sny injury or other traumatic.

State Registrar

31. Date filed (Month, Day, Year) FEB 1 5 2006

29b. Signature and title of certifies

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Attending Physician:

**Physician** 

/Medical

Examiner

Director

Funerai

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Completed

Be

**Funeral** 

Director

r than "natural", or Itams 23s or 28s-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itar any Injury or other traumatic avant, the Madical Exemina

Physician

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s been signed by t should be detact

page 2 s

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within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

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To the Hospital

Baltimore, Maryland 21215-0036

death with the Maryland

Examiner Physician/Medicai IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ COPD Completed Renal Insufficiency HBP Be 25. Was case referred to medical examiner? 1 Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 CCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

D22966

LRH Emergency Dept. 7300 Van Dusen Rd. 20707

2006

Laurel, MD

State Registrar Thomas H.

31. Date filed (Month, Day Year)

No

MD

7 2006 Register's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burguieres,

Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours after

Division of Vital Records, P.O. Box 68760, <-

an .	Decedent's Name (First, Middle, Last	st)				2. Date of Deat Month	ng. No.	3. Time o	f Death
al	MARSHALL	WADE GRO	OSSNICKI	LE		February		006 8:00	p.m.
er	4a. Fecility Name (If not institution, give				4b. City, Town, or L		4c. County		
	Beverly Healthca			Miladar I Va	Hagersto ar   If Under 24 Hrs.		Wasl	hington	
	213-30-7207	ex 7. Ag ⊋M 2□ F	e (In yrs. last bii 90	Yrs. If Under 1 Yes		8. Date of Birth (Month, Day, April 10	Year) 0,1915	9. Birthplace (State of Country) Maryland	or Foreigi
Funeral Director	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Tow	n or Location				10d. Inside C	ity Limits
	Maryland Frederi	ck	Myers	sville				1 ☐ Yes	2 No
	10e. Street end Number 3703 Bittle Road			10f. Zip Code 2177		10	og. Citizen of W USA	/hat Country?	
	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give		13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	Black	e - American Indian, k, White, etc. White	
	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed  (Specify only highest gra	Year or Dates:	16a.	Decedent's Usual Occ	upation	cina	16b. Kind of Bu		
non-line	Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of work dor life. DO NOT use ret	red)	9	Own Fa	arm	
3	6 17. Father's Name (First, Middle, Last)		1	armer	18. Mother's Nam	e (First, Middle, N			
o Re	Upton Wade Gross	nickle			Maude	Ann Gree	n		
2	19a. Informent's Name/Relationship (I	Type, Print)		o. Mailing Address <i>(Stre</i> 704 Bittle					
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place o cemete	f Disposition (Name of ry, crematory or other p	lace)	Date 2	20c. Location -	City or Town, State	
Medical Examiner	4 Donetion 5 Other (Specify  21. Signature of Frineral Service Liven	()	Grossi	nickle Ch o				ille, Mary	land
	21. Signature of Partieral Service Liveri				Funeral Ho		Main Staville	treet , MD 21773	į
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	. Fecum	Due to (or as a Due to (or as a Due to (or as a	consequence of):  way track consequence of):	ve l-Jufukú	iv +pn	emoni	6 mon	uts uts
Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	200 10 (0: 00 2	consequence or):					
Medical		d			given in Part I.	23b. Did tol	oecco use con	tribute to the cause	of death
rnysicianimedical	resulting in death) Last	d			given in Part I.			. /	
by Physician/Medical	resulting in death) Last	d			given in Part I.		s 2 No	. /	Unknow
by Physician/Medical	resulting in death) Last	d			given in Part I.	1 □ Ye	as 2 No	3 Probably  24b. Were autopsy to available prior to completion of comple	Unknow
Completed by Physician/Medical	Part II. Other significent conditions of	d		n the underlying cause	26. Place of Dea	1 ☐ Ye	a autopsy ned?	3 Probably  24b. Were autopsy to available prior to completion of comple	Unknow
To Be Completed by Physician/Medical	Part II. Other significent conditions of the sammer?  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	d	ut not resulting in	n the underlying cause	26. Place of Dea Other: Nursing Ho jury et lork?	1 ☐ Ye	n autopsy led?	24b. Were autopsy available prior to completion of confideath?	Unknow
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edical Certification: To Be Completed by Physician/Medical	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural investigation 3 Suicide 4 Homicide Homicide  29a. Certifier  1 Certifying Phi	d	out not resulting in the property of my knowledge examination and	atpatient 3 DOA  Time of niury M 1  arm, street, factory, office, death occurred at the ad/or investigation, in m	26. Place of Dea  Other: Nursing Ho jury et ork?  ☐ Yes 2 ☐ No  e  time, date and place, y opinion, death occur	24a. Was er perform  1 Year (Check only one one 5 Reside 28d. Describe how the Caty or Town and due to the cared at the time, dared at the time, d	n autopsy led?  n autopsy led?  No   24b. Were autopsy available prior to completion of of death?  1	findings to cause	
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edical Certification: To Be Completed by Physician/Medical	Part II. Other significent conditions of the sammer?  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation investigation determined 2 Accident 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	d	out not resulting in the property of my knowledge examination and	utpatient 3 DOA  Time of ninury M 1  arm, street, factory, office, death occurred at the advor investigation, in m  29c. Lice	26. Place of Dea  Other: Nursing Ho jury et ork?  ☐ Yes 2 ☐ No  e  time, date and place, y opinion, death occur	24a. Was er perform  1 Year (Check only one one 5 Reside 28d. Describe how the Caty or Town and due to the cared at the time, dared at the time, d	n autopsy led?  n autopsy led?  No   24b. Were autopsy available prior to completion of of death?  1	findings to cause	

State Registrar

31. Date filed (Month, Day, Year) MAR 0 1 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Feb. 10 2006 5:56 AM Elizabeth Harris /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Prince George's Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Yeer) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) 5. Social Security Number Birthpface (State or Foreign Country) Funeral Days Months 1 □ M 2 🛛 F June 3, Yrs South Carolina 1922 Director 129-18-1024 83 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28a-f show the Medical Exercines must be notified at 1X□Yes 2□No Director Prince George's Largo 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 9715 Lakepoint Court 20774 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 end 2 should be filed within 72 hours after nant of Health end Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify: Specify: Completed by 3 N Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Own home 10 Homemaker 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Williams Walter Williams Willie Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1001 Kings Heather Drive Bowie, MD. 20721 Steve Turman / nephew 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Depertment of H Important: If Iter any injury or oth 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/14/2006 Alexandria, VA. Metropolitan Crematory 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 9 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Curd wyssevia Difere 4-enry Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, feading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Cardial arnes Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Respirating Failor Ventilator 1 TYes 2 2No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٢ 1 Yes 2 No this After this funerel of 28c. Injury at Work? 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: A id in by the fi 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours e To the Funeral C completely filled Hospital 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier FEBRUARY 10 ZOEL 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Weensborg Rd Ligatts of HeMD 20181 DEVORE MO 42630 21 Registrar's Signature 31. Dete filed (Month, Day, Year)

Registrar **DHMH 16 Rev 6/95** 

State

FEB 1 5 2006

**ORIGINAL** 

			1 - For State Registrar	State of I	Maryland / D		nt of H	ealth and	d Mental I-	Reg. 1		16143
	Physici	ian	Decedent's Name (First, Middle, La						2. Date of Month		Day Year	3. Time of Death
	/Medi		Frances Mahala	<del>_</del>		41 03	T	1-2-2	0		07-06	14.55 M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc						eath	1	4c. County of Death	277
4.23	- L	3.00	Washington Advent 5. Social Security Number 6. S		1ta⊥ Age (In yrs. last birti		r 1 Year	a Park	Irs. 8 Date of	Birth	Montgome	
- 2.	Funeral Director			_M 2⊠F	0.7	rs. Months			in (Month.	9, 1	924 Galve	lace (State or Foreign try) ston, TX
	land Mow		10a. State 10b. County		10c. City, Town						10	0d. Inside City Limits
	Mar B-1 eh	tor	Maryland Prince	George's	Нуа	ttsvill	e					1X Yes 2 ☐ No
	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ehow na M. olcat Examinar must be notified a	ai Direc	10e. Street and Number 5821 Queens Chap	el Road		10f. Zi	Code 207	82		10g. (	Citizen of What Coun USA	try?
	deat	ner	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13. Was Dece	edent of Hi	spanic Origin?	(Specify Yes or lerto Rican, etc.)	No-	14. Race - America Black, White, e	
900	ours after rel', or its Exemine	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 {	1 ☐ Yes 2 🖺 No		1 ☐ Yes 2 No Specify:			Specify:		nite
2-0	72 h natu	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usu (Give kind of will life. DO NOT i	al Occupa	ation furing most of	working	16b.	Kind of Business/Ind	dustry
N	filed within Hygiene. other than "	Compl	Elementary/Secondary (0-12)	College (1-4d	or 5+)		emake	r			Own Home	
73	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depentment of Health and Mental Hygiene. The important: If item 23a or 28a-1 ehow important: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow any injury or other traumatic event, the M. Strat Examinar must be notified at 20ge.	To Be (	17. Father's Name (First, Middle, Last Earl Ambrose Nor						Name (First, Mide na Beatr		iden Sumame) Caldwell	
	and 2 shou ealth and N m 27 is mai		19a. Informant's Name/Relationship ( Carolyn Altman -							-	y or Town, State, Zip ark, MD 20	
w	Pages 1 and 2 ent of Health nt: If Item 27 I ry or other tre		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia			Disposition (Na y, crematory or Hill Ce		e)   ry   2/	Date 13/2006		Location - City or To	
Balti	permit. Pages Depertment of the Important: If Ite any injury or of one		21. Signature of Funeral-Service Lice		70137						eral Home, sville, MD	
F	Physician /Medical		23a. P.n.1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	line.	ot enter the mo		g, such as care			sville, h	Approximate Interval Between Onset and Death
1760,	ysician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (	as a consequence of	leal	Ci	for	for			
.O. Box 68	00	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 Fetal death at time of death	3 ⊟Ectopic p 5 ⊟ Other (s					23d. Date of delive Month	ry Day Year
ds, P	uires that signed b		Part II. Other significant conditions of	contributing to deat	n but not resulting in	the underlying	cause give	en in Part I.			ouse contribute to th	,
Records,	. The law requires that the sate has been signed by the page 2 should be detached.	Completed							_ pe	topsy rformed	prior to con death?	psy findings available inpletion of cause of
		0	25. Was case referred to medical				10000	26 Place of	1 ☐ Ye Death <i>Ch</i> eck on	-	NO 1 1 195	2 NO
>	S 0 5	0 8	examiner?	Hospital:	atient 2 ERVOut	patient 3 D	OA Othe	ar.			6 □Other (Specify	/)
	After fune	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio	28a. Date of I (Month,	njury 28b. T <i>Day Year)</i> Ir		28c. Injun Work				jury occurred	,
É	al or Attend s after death al Director: A d in by the f	Certification:	3  Suicide 6 Could not be determined	e of Injury - At home, farm, street, factory, office ing, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the be niner: On the basis and manner	of examination and	, death occurred Vor investigation	d at the tim	e, date and ploinion, death o	ace, and due to to courred at the time	ne cause le, date a	(s) and manner as stand due to	ated. the cause(s)
	vithin 2 ro the complet	M	29b. Signature and title of certifier	1 /		29	c. License			29d. [	Date signed (Month, L	Day, Year)
	0	1	1 full	1/1	per		45	203			2/9/2006	)
)	(4)		30. Name and address of person who	completed cause of	of death (Item 23a) (	Type, Print)						
	<b>U</b>		Stephen Smith	921	O Corpora	te Blvd	, Ste	210,	Rockvill	e, M	D 20850	
	Sta Regist		31. Date filed (Month, Day, Year) FFB 1 4 200	Region Region	strar's Signature	fall						

DHMH 17 Rev 1/2001

				State of N	/laryland /	Depar Cert	tment of <i>ificate o</i>	Health a f Death	and Me		iene () ( eg. No.	)6	061	44									
			1. Decedent's Name (First, Middle, La	st)					2.	Date of Deat Month	h Day	Year	3. Time of	of Death									
	Physici /Medio		John Lewis H	illyer					F	ebrua:			7:20	pm									
17.00	Examir		4a. Facility Name (If not institution, give		r)			•		ion of Death	4c. County	of Death											
			7000 Greely Ro				If Under 1 Ye	Lando		Data of Dinth	PG	o Bisto I	/0:										
	Funeral			Sex 7. # 15√2 M 2 □ F	Age (In yrs. last b 69	Yrs.	Months Day		Min.	Date of Birth (Month, Day, U1V 1	Year) 3,1936	Count	ace (State ny) NC	or Foreign									
	Director		Usual Residence of Decedent		0.9				0	иту т	3,1330												
	yland		10a. State 10b. County		10c. City, Tox							10	d. Inside (										
	e Ma	cto	MD PG		Land	over							1½ Yes	2 🗌 No									
	ith th	Dire	10e. Street and Number				10f, Zip Code			1	0g. Citizen of V	What Count	ry?										
	s 23a	ra	7000 Greely Ro		· E · 25 II O	40.111	2078		· · 0 /0 · · -:		USA	e - America	n Indian										
020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2√ If Yes, Give Year or Dates	s? ] No		as Decedent of Yes, specify C ☐ Yes 22 ☐ √1	of Hispanic Originals of Hispanic Originals	gin? (Specir i, Puerto Ric	y Yes or No- an, etc.)	Blac	K, White, e	etc.										
21215-0020	2 hou	Completed by	15. Decedent's E	ducation	168	a. Decede	nt's Usual Occ	cupation	t of wordsing		16b. Kind of Bu	usiness/Ind	ustry										
215	within 7 ene. than "n	ple	(Specify only highest grant   (Speci	r 5+)	life. DO	O NOT use ret	,			<b>a</b>													
	ed wi	5	12		C	arpe	nter/	Crafts			Carper												
Maryland	be fill tel H d oth	Be	17. Father's Name (First, Middle, Last George Lewis	Hillye	r			18. Mothe			<i>Maiden Surnam</i> Edward	. *											
7	12 should b h and Mente ' is marked raumatic e	ဥ				h Mailing	Addross (Str				City or Town,	-	Codel										
Ma	d2st thanc :7 is m traun		19a. Informant's Name/Relationship (Frances Hillye)			_					MD 20		0000)										
ē,	s 1 an l Heal tem 2 other		20a. Method of Disposition		20b. Place	of Disposi	tion (Name of atory or other p	-			20c. Location -		vn, State										
Ë	Pages nent of H ant: if ite ury or of		†☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the C		Harm	_	nory or ourier p	nace/	2/	13/06	Land	dover	, MI	)									
Baltimore,	permit. F Departme importan any injur		21. Signatur uneral Service Lue	nste Lucia - l	la lour	J O	e Bal	t • FH,	у		h St,												
			23a. Part1. Enter the disease, or comshock, or heart failure. is only	plications that caus	ed the death. Do		the mode of o	lying, such as	cardiac or re	espiratory arre	est,		Approxima Interval Be	ate									
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Col	Due to (or as a	ence	21						Onset and										
68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the buriel-transit	eted by Physiclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as a																		
P.O. Box			Part II. Other significant conditions of	deontributing to death	but not resulting	in the unc	lerlying cause	given in Part I.			bacco use co	ntribute to		of death?									
Records, F			þ	٥	þ	þ	þ	þ	Completed by F	<u>م</u>	۵	۵								24a. Was a	n autopsy ned?	ava	re autopsy ilable prior
Rec		gu								404	es 2 🗖 No		eath?	7 N.									
ā	n: The ficate or, pa		25. Was case referred to medical					26 Place	of Doath //	1 □ Ye	/ \		Yes 2L										
>	Physicien: r this certific rral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ Inpa	tient 2 ER/C	Outpatient	3□ DOA	Othor:			ence 6 □Oth	er (Specify	)										
jo l	g Phy er this ieral c		27. Manner of Death	28a. Date of In (Month, L	iurv 28b.	. Time of Injury	28c. Ir			7.5	w injury occur												
io	Attending or death. ector: After by the fune	atio	1 Natural 5 Pending investigation	n	,	,,		☐Yes 2☐	No														
Division of Vital	or Atte efter de Directo in by ti	iği	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	njury - At home, t etc. <i>(Specify)</i>	farm, stree	et, factory, offic	се	28f	Location (St City or Town	reet and Numb , State)	er or Rural	Route Nu	mber,									
Ω	To the Hospital or Attending Physicien: The law within 24 hours efter death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	Medical Certification:	29a. Certifier (Check only one)  Certifying Property one)	nysician: To the bes niner: On the basis and manner	of examination a	ge, death o	occurred at the	time, date an	d place, and th occurred	I due to the ca at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ated. the cause	(s)									
	o the ithin; o the omple	Me	29b. Signature and title of certifier	and manners			29c. Lice	ense number		2	9d. Date sign/e	d (Month, D	Day, Year)										
	F 3 F 8		· All	1			D	20980	9		2/1	6/06	7										
R	(5)		30. Name and address of person who Elwood Hollan	completed cause of	death (Item 23a)	Type, P	rint) Suit.	23, Ch	never	ly, MY	2078	25											
	Sta	te	31. Date filed (Month, Day, Year)	32 Regis	strar's Signature		~~																
	Registr	ar	FEB 1 6 20	Us the	te K	Apre																	

DHMH 16 Rev 6/95

Use   Street and Number   10c. City, Town or Location   10d. Inside City   10d. City   1	Physicia	n	For State Registrar 2–16–06 Amen  1. Decedent's Name (First, Middle, L	State of Mad#4b.PerPhys.	arylan PGC C	d / Depa r <i>Cei</i>			ealth a Death			leg. No.	006	9	6 4 5 3. Time of Deal
The State   100. County   100.	Examine Funeral	er	Font wilhings 5. Social Security Number 25/36 6417	Sex N 7. Ag	hek e (in yrs.	0	II Unde	r 1 Year	If Under	es Ars.	Washir ton B. Date of Birt (Month, Day	h v, Year)		Country	CRG es (State or For arolin
Security only impress grade completed   College (1-dor 5-)   College (1-dor 5-)   Chef   Federal Government   Chef   Ch	e Maryland	ctor	10a. State 10b. County					ghts							. Inside City Lir
Comment of a work down during most of working   Security   Secur	3a or 28	Dire		ghts Boleva	ard		10f. Zi	p Code	207	43		10g. Citiz		Country	?
Specific of the protection during most of working   Specific or the protection of	ours atter deatt	by Funera	1 Never Married 2 Married	1 □ Yes 🗶 🕅	Ever in U.	į					rty Yes or No- ican, etc.)		Black, W	hite, etc	).
1. Part   Part	na na	mpieted	(Specify only highest g Elementary/Secondary (0-12)	rade completed)	5+)	(Give lite.	kind of we DO NDT t	ork done d	during mos	t of working	g				•
Second   S	Antal Hygir Red other tic event,	Be	17. Father's Name (First, Middle, Las			Cire	L					Maiden .		GOV	ernment
23a. Part Lefter the disease, or complications that caused the death. Do not enter the mode of dying, ach as cardiac or respiratory arrest, immediate Cause (Final disease or contributions) and the past 12 months?    Popular of the past 12 months?   Due tr (or as a consequence of):	irmit. Pages 1 and 2 shr spartment of Health and portant: If Item 27 le m injury or other traum.		Samoris Hall - S  20a. Method of Disposition  ↑ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	On □Removal from State	0	203 B Place of Disposemetery, crei	onhi esition (Na natory or	11 Di	rive;	Fort Da 2/10/	Washi	n to 20c.Lo	n . MD cation - City	20 or Town	744 n, State ryland
Solution   Solution	Medical  Physician and The burial-transit  The	cal	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	a conseq	uence of):	er the mo	le of dyin	gachas	cardiac or	Para l	Ary	,		pproximate in roal per la construction of the
1   Yes   2   No   3   Probably   4	atter for u	ysician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 Feta	I death 3						2			
autopsy performed?   1   Yes 2   No   No    25. Was case referred to medical examiner?   25. Was case referred to medical examiner?   1   Yes 2   No    26. Place of Death (Check only one)    27. Manner of Death   1   Natural   2   ER/Outpatient   3   DOA    27. Manner of Death   1   Natural   2   Accident   3   Suicide   4   Homicide   4   Homicide   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Num City or Town, State)    28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Num City or Town, State)    29e. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    29e. Signature and Mile of certifier   29e. License number   29e. Date signed (Month, Day, Year)    29e. Signature and Mile of certifier   29e. License number   29e. Date signed (Month, Day, Year)    29e. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    29e. Signature and Mile of certifier   29e. License number   29e. Date signed (Month, Day, Year)    29e. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.    29e. Signature and Mile of certifier   29e. License number   29e. Date signed (Month, Day, Year)	igne be c	Þ.	Part II. Other significant conditions	contributing to death t	out not res	ulting in the u	nderlying	cause giv	en in Part 1	l.					
25. Was case referred to medical examiner?	e la has je 2	Complete									autor perfo	osy rmed?	death	1?	
The property of the property o	yalcian s certifi director	Be	examiner?	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatie	nt 3 🗆 🗅	OA Oth					S □Other (S	Specify)	
29a. Certifier (check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	ding Fune	ertification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In	jury - At h	Injury ome, farm, st	М	1 🗆		No	8f. Location (.	Street and	d Number o	r Rural I	Route Number,
	e Hospital	dical C	(Check only 2 Medical Ex	aminer: On the basis of	of examina	owledge, deat ation and/or in	h occurred vestigatio	d at the tin	ne, date ar pinion, dea	nd place, at	nd due to the d at the time,	cause(s) date and	and manne place, and	r as stat	ed. he cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the comp	Me	N 8	W				oc. Licens	e number	35					/

	1 - For State Registrar	of Maryland / Depa <i>Cel</i>	artment of He rtificate of D	Death	Reg. No.	06 06 146
Physician /Medical	Decedent's Name (First, Middle, Last)     JAMES	HAWKINS		N.	Date of Death Month Day	3. Time of Death 2006 8:54 A
Examiner	4a. Facility Name (If not institution, give street and n 4915 Eastern Ave 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	4b. City, Town, or  Hyattsvi1  If Under 1 Year  Months Days	Location of Death	4c. (	County of Death  Ce George 's  9. Birthplace (State or Fore Country)
Director	579-26-5246	78 Yrs.		Mar	ch 2, 192	27 Washington D
vith the Mar or 28a-f st be notified Director	MD Prince George 1	s Hyattsv	rille 10f. Zip Code		10g. Citiz	12∑ Yes 2 ☐
be tiled within 72 hours atter death with the Maryland and bytylene.  dictor than 'natural', or items 23a or 28a-f show dictor than 'natural', or items 23a or 28a-f show event, the Maryland Examit or mark be notified at event, the Maryland Examit or mark be notified at Be Completed by Funeral Director	1 Never Married 2 Married 1 Pyes	Forces?	20782 Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Specify n, Mexican, Puerto Rican Specify:	Yes or No-	ed States  4. Race - American Indian, Black, White, etc.  Specify:Black
ed within 72 houygiene. Ygiene. Yer than "nature t, Ire M. cire.!!	12	(Give life.	Handler	uring most of working	Gove	d of Business/Industry
Mental Hy Mental Hy Mrked oth atto event	17. Father's Name (First, Middle, Last) Frank Kelly			18. Mother's Name (First Selma Hawk		Sumame)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If them 21 is marked other than 'naturel', or iteme 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)  Mary Hawkins/ Wife  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fror  4 ☐ Donation 5 ☐ Other (Specify)  21. Sign was if Funeral Service Licensee	20b. Place of Dispo cometery, crea Marylan Cemeter	outhern Avasition (Name of matory or other place d Veteran	ve SE #203	Washingto	eation - City or Town, State
physician and physician and physician and physician and physician and sthe burial-transit and physician and physic	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	EROSCLEROSIS o (or as a consequence of): ERTENSION c (or as a consequence of): o (or as a consequence of):				Interval Between Onset and Death
y the attending iched for use a nysiclan/Me	in the past 12 months?	gnant at time of death 5	□Ectopic pregnancy □ Other (specify)		2	3d. Date of delivery Month Day Year
5 B 6	Part II. Other significant conditions contributing to GOUT	death but not resulting in the u	inderlying cause give	n in Part I.		se contribute to the cause of death?  No 3 Probably 4 Unkno
ate has b page 2 sl					24a. Was an autopsy performad? 1 Yes 2 No	24b. Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 【※No
tending Physically.  tor: Atter this the tuneral directly.	the state of the s	Inpatient 2 ER/Outpatien e of Injury onth, Day Year)  28b. Time o Injury ce of Injury - At home, farm, st	of 28c. Injury Work M 1 \( \text{Y}	at 28d. ? (es 2 \( \subseteq No \)	Residence 6 Describe how injury	occurred  Number or Rural Route Number,
within 24 hours after of to the Funeral Direct completely tilled in by Medical Certiff		Iding, etc. (Specify)  he best of my knowledge, deat basis of examination and/or in	th occurred at the time	e, date and place, and o	City or Town, State)  due to the cause(s) t the time, date and	and manner as stated.
within 22 within 22 complete	29b. Signature and title of certifier  30. Name and address of person who completed ca	anner stated.	29c. License #MD 01	number .01055143	29d. Date	a signed (Month, Day, Year)  ARY 9, 2006
State Registrar	MARCUS PHILIP NADLER, M. 31. Date filed (Month, Day, Year) FFB 1 6 2006	Registrar's Signature	IKVING STE	CEL NW, WA	DUTNGION,	DG 20422/008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 02 Mabel Marie Heindel 2006 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Chapel Hill Nursing Home Randallstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 ⊞ F 86 220-03-6520 Director 07/03/1919 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "neturel", or iteme 23e or 28e-f show other traumatic event, the Nedical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Upperco Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5405 Fifth Ave. 21155 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ∰ No If Yes, Give ∰ Year or Dates: Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 # No Specify: Completed by 3# Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Alban Florence Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna V. Cullison Sister 5405 Fifth Ave. Upperco, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it eny injury or o 1 

Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) St. Pauls Cem. 02/13/2006 Upperco, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home Eline Steven MU0723 934 South Main Street Hampstead, MD W. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical attending physic 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s 1 Yes 2 ₽No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Wed in by 4 - Homicide To the Hospital within 24 hours a To the Funeral completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Maren L. Balrit, M.P. DO058676 February 10, 2006 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 25 Main Street, sulte 200, Reisterstown Karen L. Babitt, M.D. 32. Rei strar's Signature 31. Date filed (Month, Day, Year) State FEB 10 2005 Registrar

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_	Registrar  1. Decedent's Nar	ne (First, Middle	e, Last)			rtificate of		2. Date Monti		Year	3. Time of Dea
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	21. Signature of	Funeral Service	Licensee	0010		2. Name and Add		ein e m	RUNAM 1	TINEPAT	HOME P.A
	Joseph	w.	Ostrowski	C+15/2	21						
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ဗ္	ral', o	þ	3 ☐ Widowed 4 ☐ Dive	orced	If Yes, Giv Year or Da	6	7 1 1	1 ∐ Yes	2 <b>XX</b> 10	Specify:			Specia	y:White	е
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2	hen.	ig II	Elementary/Secondary (0	- i	College (1	-4or 5+)	Zonin		use retired	•			D.C. G		
2	ited w lygie lher ti nt, in		17. Father's Name (First, Mi	ddle (ast)			ZOLLLI	R III	speci		r's Name	/First Middle	, Maiden Sumai		менс
Maryland	od of	Be			Con									110)	
<u>_</u>	should Me mark mati	ဥ	James A. Her	_			19b. Mailin	na Addre	ss (Street a			Curtis	er, City or Town	. State. Zip	Code)
S	ulth ar 27 io r trau		James A. He			Son							ing, Ma		- 7.6
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural; or itams 23a or 28e-f show marked in Item 27 is marked other than "natural; or itams 23a or 28e-f show in Item 1011/200 of the traumatic event, the Modical Example regarded to the profiled at once.		20a. Method of Disposition		······	20b.	Place of Dispo	sition (N	ame of			)ate	20c. Location		
E	Page nt: #		#⊞Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			state	•	-		1	2/1/	1/2006	Brontu	and A	Maryland
Baltimore,	porting y inju	1	21. Signature of Funeral Se	ryjoy Licens	99 /	4.	22	. Name	and Addres	ss of Facilit	y Hine	s Rina	ldi Fun	eral l	Home
<u> </u>	89 = 8	1	tour	+ 16	den	Mi	1	1800	New	Hamps	shire	Ave S	ilver S	pring.	MD 20904
	Physician /Medical Examiner		23a. Part1. Entey the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	se, or compli List only or	Card	ach line.	monary .			g, such as	cardiac	r respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated avents resulting in death) Last		s	or as a conse									
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.O. Box	that the death certific led by the attending p detached for use as	Physiclan/Me	23b. Was decedent pregnal in the past 12 months? 1 Yes 2 No 9 Unknown	11,		inth 2 ☐ Fet ant at time of	aldeath 3⊑	]Ectopic ] Other (	pregnancy specify)					ate of deliver onth	Day Year
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rds,	w requires that been signed is should be det	ğ D	Hypertension	1								1 🗆	Yes 2□No	3 🗆 Proba	ably 420 Inknown
Vital Record	law re-	Completed by										24a. Was		Were autop	osy findings available
æ	The jay te has age 2	E										auto perfo	ormed?	prior to con death? 1 \( \text{Yes} \)	npletion of cause of
ital		0	25. Was case referred to me	edical						26. Place	of Death	(Check only		12,100	22710
<b>_</b>	Physician: The la this certificate had ral director, page 2	To B	examiner? 1 Tes ZONO	H	fospital: 1 ☐ Ii	npatient 2	ER/Outpatien	it 3 🗆 🛭	Oth	er: 4X Nu	rsing Ho	me 5 Resi	idence 6 □Otl	ner (Specify	)
n of	<u>a</u> = <u>re</u>		27. Manner of Death	ending	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time of Injury	F	28c. Injury World	/ at k?		28d. Describe	how injury occur	rred	
Sio	Attending in death. ector: After by the fune	cati	2 Accident in	vestigation ould not be				М	10	Yes 2 ☐ I	No				
Division		Certification;	4 ☐ Homicide d	etermined	buildir	ng, etc. (Spec						City or To			
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	edical	29a. Certifier 1 Cel (Check only 2 Mer	tifying Phys dical Exami	sician: To the ner: On the ba and mann	usis of examin	owledge, death ation and/or inv	occurre vestigation	d at the time on, in my op	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of c	ertifier				2	9c. License	e number			29d. Date signe	ed (Month, L	Day, Year)
)	10		// // // // // // // // // // // // //	N					D56	147			Februa	ary 10	, 2006
			30. Name and address of pe	erson who co	ompleted caus	e of death (Ite	m 23a) (Type,	Print)							
			Nasreen Ka	ngo.	M.D. 7	7610 Ca	rroll	Aven	ue #2	05 Ta	koma	Park.	Marylar	nd 2	0912
12	Sta Registi		31. Date filed (Month, Day,	Year)	32 <b>3</b> R	egistrar's Sign	ature And	3 ME	9		1856		- ,		

			State of Maryland / Department of Health and  1- State Registrar  Certificate of Death	Mental Hyg	iene og. No. 0 0 6	06150
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death
	Physicia /Medic		MARGARET NOREEN HOFFMAN			06 6:10AM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deal	th	4c. County of Deat	h
			1341 Redwood Circle La Plata		Char	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		212-34-3376	OCT.12	2,1948 WA	SH.,DC
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aanyl F sho	ō	MADYIAND QUADIDO LA DIAMA			1 □ Yes 212710
	the the 28a-	Director	MARYLAND CHARLES LA PLATA  10e. Street and Number 10f. Zip Code	10	og. Citizen of What Co	untry?
	with Ba or				II C D	
	Jeath Trs 2:	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (5 ff Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	U.S.A. 14. Race - Ame	
(0	r itar	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puer  1 □ Never Married 2X Married 1 □ Yes 2 2 No	rto Rican, etc.)	Black, Whit	e, etc.
03	al', o	þ	If Yes, Give 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: WH	ITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show tha Madeal Examinat must be molified at	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	orkina	16b. Kind of Business	Industry
2	ithin Ban	nple	Elementary/Secondary (0-12) College (1-4or 5+)		1cDONALD	& EUDY
2	filed with Hygiene. other ther	Co	12 1 VICE PRESIDENT		PRINTING	CO.
nd	be fill	Be		me (First, Middle, M		
yla	should be ind Mental I marked o	၉			RUPPERT	
Maryland	2 sho		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address (Street and Number or R  THOMAS A. HOFFMAN-HUSBAND 1341 REDWOOD CIRC			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; or itams 23a or 28a-f show any injury or other traumatic avant. Its Marical Examinat must be notified at angre injury or other traumatic avant. Its Marical Examinat must be notified at angre.			-	20c. Location - City or	
Baltimore,	ges 1 t of H If ital		1 ☐ Burial Stromation 3 ☐ Removal from State		•	
ţ	permit. Pages: Department of I Important: If its any injury or ot			-22-06	ALEXANDRI	A, VA
3ali	permit Depar Impor any in		21. Signature of Fineral Service Licensee MOO47 2. Name and Address of Facility RAYMOND FUNER	AL SERVI	ICE, P.A.	
	Ø □ 〒 ♥ Ø		23a. Part 1. Enter the disease, or complications that caused the death. Danot enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	OC CIANTO	16.16	Approximate
760, <-	Pnysician / Medical Examiner    Medical Examiner	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. First Industryin Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		,,,	Onset and Death
P.O. Box 68	t the death certifics by the attending ph ached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify) 9  Unknown		23d. Date of del Month	Day Year
	es tha igned be det	by	Part II. Other significant continuous continuous to death but not resulting in the underlying cause given in ranci.		acco use contribute to	
Records,	w requir been si should	Completed		1 Ye	s 2 No 3 Pi	obably 4 Unknown
ecc	e faw r has be ye 2 sh	ple		24a. Was ar autops	y prior to	topsy findings available completion of cause of
<u> </u>	The ate h page	Con		perform	ned? death?	2 🗆 No
Vital	cian: ertific	Be (	25. Was case referred to medical against 26. Place of De	eath (Check only on	9)	
of V	Physician: The la r this certificate has ral director, page 2	ို	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	-	nce 6 Other (Spe	cify)
п	fte an	Certification:	27. Manner of Death 28a. Date of Injury 1. □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of lnjury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
sio	Attanding ir death. ector: Atterby the funer	cat	2 Accident investigation 3 Suicide 6 Could not be	1 001 1		
Division	I or Attandi after death. Director: A I in by the fu	E	4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or R. r, State)	ural Houte Number,
	urs a			1		
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)   1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and manufactured at the time, date and manufactured at the time, date and death occurred at the time, date a	e, and due to the ca curred at the time, da	iuse(s) and manner as ate and place, and due	to the cause(s)
	To the within 2 To the complet	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number	25	9d. Date signed (Mont	h, Day, Year)
	¥ ¥ 5 8		Marie Myadla NLEZT		7/17/	01
			11-16-	_	011/1	U
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MS	2064	6
•	Sta Registi		31. Date filed (MAR Pay O Year) 2006 Registrar's Signature			

				For State Registrar	1 1000			and / Dep		nt of H	łealth a	and Me	ental Hy		•	06151
	8	1		Decedent's Name (	(First, Middle,	Last)							2. Date of De	ath		3. Time of Death
	3	Physici		DAVID		Ε.			JACKS	ON		F	Ebrua	NG Day	7, 200	6 8:30PM
		/Medic Examin		4a. Facility Name (If n	not institution, g		mber)				r Location of	of Death		1.17	County of Dea	
	1	LAGITITI	CI	DOCTORS C	OMMUNI	ry Hospij	FAL		LAN	HAM				PR	INCE G	EORGE
	ŧ,	Funeral		5. Social Security Nun	mber 6	Sex 1 M 2 □ F	7. Age (In y	rs. last birthday	) If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. (	8. Date of Bir (Month, Da 18-22-1	th v Year	9. Bir	rthplace (State or Foreign
	175 ( ) 175 ( )	Director		212-19-609	6	1 Ø M 2 □ F	32	Yrs.	Months	Days	Hours	0	8-22-1	973	WAS	HINGTON, DC
		pu >		Usual Residence of D			100	City, Town or t	ti							10d. Inside City Limits
		anyla shov	-		10b. County											1 Yes 2 No
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		death with the Maryland rms 23s or 28s-f show	Funeral Director	10e. Street and Numb					10f. Zij					-	S.A.	ountry?
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2	936	al', o		3 ☐ Widowed 4		If Yes, Gir Year or D	ve	İ	1 🗆 Yes	2 🕅 No	Specify:				Specify: B.	LACK
ackson	0-10	within 72 hours after ane. than "natural", or Ite	Completed by	(Specific	15. Decedent's	Education		16a Dec	edent's Usu	al Occup	ation	t of working		16b. Kir	nd of Business	s/Industry
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12	7	ygien yer th	Con	11th					GLAZI	ER						
)	nd	be file tal Hy d oth	Be	17. Father's Name (F)									(First, Middle,	, Maiden	Sumame)	
- 1	yla	Men Men arke	2	WILLIAM D								TE MA				
david	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importments if time 27 is marked other than "natural", or thems 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be multiled at Once.		19a. Informant's Nam WILLIAM D			7.R	4	-					-	r Town, State,	Zip Code)
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_				shock, or heart	I ure. List or	nly one cause on e	each line.						respiratory a	11651,		Approximate Interval Between Onset and Death
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	ŏ	th cer endir r use	an/la	IF FEMALE: 23b. Was decedent p		23c. If yes, ou	tcome of pre		□Ectopic p	regnancy	,			2	23d. Date of de	•
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	Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death certificate be excreted: r death actors. After this certificate has been signed by the attending physicien by the funeral director, page 2 should be detached for use as the buria		Part II. Other significa	ant condition	s contributing to a	eath but not	resulting in the	underlying	cause giv	en in Part i			Yes 2[		to the cause of death?  Probably 4 Munknown
	oro	w requir been si should	eted										-		7110 001	Tobably 4 April 10mi
	ec	e law has b	Completed										24a. Was auto	psy	24b. Were a prior to death?	utopsy findings available completion of cause of
	<u>=</u>	r: Th	S										1 ☐ Yes	ormed? 2⊠No	1 ☐ Ye	
	Zi Zi	ricier certif rector	Be	25. Was case reterred examiner?		Hospital:		1		Ctt			(Check only o			
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	on	ding h. Afte fune	tion	1 Natural 2 ☐ Accident	5 Pending investiga	(Mon	th, Day Year	r) Injury	М	28c. Injut Woi 1 □	rk? Yes 2 □				,	
	/isi	Atten deal ctor	fica	3 🗌 Suicide	6 Could no	t be 28e. Place	of Injury - A	At home, farm,	treet, lactor	y, office		21	Bl. Location (	Street and	d Number or F	Rural Route Number,
		al or after	Certification:	4  Homicide	dotomin	build	ing, etc. (Sp	ecify)					City or To	wn, State,	)	
		To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After his certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier 1 (Check only 2 one) 2	Certifying	Physician: To the kaminer: On the b	e best of my easis of examiner stated.	knowledge, dea nination and/or	th occurred	at the tin	me, date ar opinion, dea	nd place, ar ath occurred	nd due to the d at the time,	cause(s) date and	and manner a place, and du	as stated. le to the cause(s)
		To th within To th compl	Me	29b. Signature and tit	itle of certifier	_			29	c. Licens	e number		,	29d. Dat	e signed (Mon	nth, Day, Year)
				▶ A	Hen	u Va	nus	ler		10	19	446	0	Fob	ruary	9,2006
	2 1/	0 (5)		30. Name and addres		ho completed caus	se ol death (	Item 23a) (Type	e, Print)			1 44	2010	. ( ~	· renry	-
(				Steven Rev				Street	Suite.	351	Laure	el Ma	2070	7		
		Sta Registr			B 1 4 20		legistrar's Si	B L	W.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1,perME,g853,perME,g853,3/72/05 11

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death February 2006 Physician 12:10P.M Phillip Landon Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner **Beltsville** Prince George's 4604 Brandon Lane If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Utah 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Months 58 564**-**64**-**6600 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28e-f show injury or other treumetic event, the Madical Examiner must be nutified at Maryland Prince George's Beltsville 1 ☐ Yes 2 X No Directo 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number ö 4604 Brandon Lane 20705 United States Items 23e permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e eny injury or other treumetic event, Ite Madical Examiner must once. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status I TX/es 2 No If Yes, Give 1966-1968 Year or Dates: X Never Married 2□ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bartender Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Lucille Coulter Galen Robert Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Leupen -friend 4334 Sellman Road Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/10/2006 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Jonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of): Friysician Ciarhosis /Medical Examiner Alecholis. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown and mia page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Hospitei or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel C 29a. Certifier McCortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 FEB 14 The sales Registrar

				State of Ma	aryland / Dep	artment of	Health and	Mental Hyd	riene	•
			1 = For State Registrar	Oldio of Ivio		ertificate of			Reg. No. 0 0 6	06153
V	<b>13</b> 13 1		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
-	Physici /Medic		WILLIAM EI	OWARD J	ACKSON			FEB.	6, 2006	10:45A M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of De		4c. County of De	
			Shady Grove Adv				ckville		LUOW	GOMERY
	Funeral		5. Social Security Number 6. Sex	7. Age Mg 2□F	e (In yrs. last birthday 80 Yrs.	Months Days		in. (Month, Day	h y, Year) 9. E	irthplace (State or Foreign Country)
	- Director		578-42-5075		110.			May 10	,1925 M	laryland
	yland		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	a-f-et	ctor	MD Montgo	omery		Germant	own			Yes 2 □No
	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w	ral	1 Scottsbury				20876		U.S.	
	er de	nue	The state of the s	12. Was Decedent E Armed Forces?	Ever in U.S. 13	Was Decedent of If Yes, specify Cul	Hispanic Origin? ban, Mexican, Pui	(Specify Yes or No- erto Rican, etc.)	- 14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	irs aft	by Funeral Director	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 Tyes 2 1	10	1 ☐ Yes 2 🗓 No	Specify:		Specify: B	lack
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or itema 23e or 29e-1 ehow Is Madrell Everniner runk be notilled an	ted	15. Decedent's Educ	cation	16a. Dec	edent's Usual Occu	pation		16b. Kind of Busines	ss/Industry
2	hin 7 8.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life.	e kind of work done DO NOT use retir	ed) most of w	vorking	Marylan	d State
7	ed wii	Completed	8th			Truck	Driver		Highway	
pu	tal Hid of	Be	17. Father's Name (First, Middle, Last)					lame (First, Middle,		
2	d Mer narke	2	Unknown	Driet	105 14-3	E Add (Ch		lda Jack		7.0.11
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or itema 23s or 28s-1 show among injury or other traumatic event, the Macinal Examination and page.		19a. Informant's Name/Relationship (Ty)  Mary Contee (D			_			er, City or Town, State Ltown , MD	
ē,	Heal tem 2		20a. Method of Disposition	adgireer	20b. Place of Disp	osition (Name of		Date	20c. Location - City	
Baltimore,	ent of		1 XBurial 2 ☐ Cremation 3 ☐R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ematory`or other pla wn Mem		/15/06	Rockvi	lle, MD
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m	9 a ii 9		GOODE KI	Lun	velly	246 N.	Wash.	St., Ro	ckville,	MD 20850
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused le cause on each lin	the death. Do not e	nter the mode of dy	ing, such as card	iac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pulse	less Ele	ctric A	ctivity	7		Onset and Death  Immediate
	/Medical Examiner		resulting in death)		a consequence of):					
		J.	Sequentially list conditions,	Cereb	ral Vasc	ular Di	sease			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (01 40 1	a 3011004201100 01).					
<u> </u>	te be executed ysicien and ie burial-transit	Еха	that initiated events cresulting in death) Last	Due to (or as a	a consequence of):					
,160		cal		J						
89	The law requires that the death certifica sie has been signed by the attending ph bage 2 should be detached for use as it	Med	IF FEMALE:							
ê	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 Fetal death 3	□Ectopic pregnand	су		23d. Date of d Month	elivery Day Year
.O. Box	he de the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death 5	Other (specify)				34,
Δ.	that the by detac	/ Ph	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the	underlying cause g	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds	uires n sign ild be	d by	Coronary	Artery	Disease			1 □ Y	′es 2 □ No 3 □	Probably 4 Unknown
000	s been signatured should b	olete			010000			24a. Was a		autopsy findings available
R	The lay	Completed						- autop: perfor 1 ☐ Yes	rmed? death	o completion of cause of es 2 No
<u>ta</u>	ysician; Th is certificete director, pag	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or		20110
>	Physic this ce ral dire	2	1 ☐ Yes 2 🛣 No	ospital: 1 ☐ Inpatie		ALL SEL DON		Home 5 ☐ Resid	dence 6 □Other (Sp	pecify)
Ĕ	ding P. h. After t funera	ö	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	We		28d. Describe h	now injury occurred	
Division of Vital Records,	Attending Physician: r death. ector: After this certifice by the funeral director, p	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Init	ury - At home, farm, s		]Yes 2 ☐No	28f Location (S	Street and Number or	Rural Route Number
<u>&gt;</u>	for Attendated after deatl Director:	Certification;	4 Homicide determined	building, etc	:. (Specify)	ireer, ractory, office	,	City or Tow		nurai noute ivulliber,
	e Hospital 24 hours a e Funeral l letely filled		29a. Certifier 1 Certifying Phys	ician: To the best o	of my knowledge, dea	th occurred at the	time, date and pla	ice, and due to the c	cause(s) and manner	as stated.
	To the Hospital or Attentivitin 24 hours after deatle To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examir one)	ner: On the basis of and manner sta	examination and/or i ited.	nvestigation, in my	opinion, death oc	curred at the time, o	date and place, and d	ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	m. 0		29c. Licer	se number	2	29d. Date signed (Mo	nth, Dey, Year)
•	6						054139		Feb. 6	, 2006
	_		30. Name and address of person who co							00070
	Sta	te.	Duc Tuan Le,  31. Date filed (Month, Day, Year)				nter Dr	., Rock	ville, M	20850
e d	Registr		FEB 14 2	006	ar's Signature	general				

			State Registrar	State of Marylan		artment of F		R	eg. No.	6 06154
	Physicia	an	1. Decedent's Name (First, Middle, Last)	1				2. Date of Deat Month 02 2	Day Y	3. Time of Death
	/Medic	al	Mary Elizabeth Jos 4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Dea		2 2006 4c. County of	1:33 A M
	Examin	er	St. Vincent DePaul		ter	Frostbu			Allegan	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days				B. Birthplace (State or Foreign
	Director		213-10-0209	<sup>M 2</sup> □XF 89	Yrs.	Worth's Days	Tiodis Will	Feb 22	, 1917	MD
	and		Usual Residence of Decedent  10a, State 10b, County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl f eho	Į.	MD Allegan	y	Cum	berland				1 💢 Yes 2 🗆 No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	•
	th with	aiD	608 Haddon Avenu	е			21502		US	Α
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show supprishing to other traumatic event, the Marietal Extending manual ke notified at once.	y Funeral Director	11. Marital Status 1  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	Black,	American Indian, White, etc.
8	2 hours	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busi	
215	hin 72	Completed by	(Specify only highest grade	completed) College (1-4or 5+)		kind of work done DO NOT use retired	during most of wi d)			
2	ed with	Corr	Elementary/Secondary (0-12)		Hcme	maker			Own Hor	
yland	Mental Hy Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) George Edward	Klosterman			Esthe	r Donahoe	Beck	
, Mar	and 2 sho satth and n 27 te m		19a. Informant's Name/Relationship (Typ. Dolores Mace	daughter		1	Avenue			MD 21224
Baltimore, Maryland 21215-0036	Pages 1 nent of He ant: If Iter ury or oth		20a. Method of Disposition  1 → Surial 2 → Cremation 3 → Ro 4 → Donation 5 → Other (Specify)	mayal from State	emetery, cres	sition (Name of natory or other plac Demetery	сө)	2/24/2006	Cumber	ity or Town, State
Balt	Departr Departr Importu eny inji		21. Signature of Furieral Service License	1 Acarpol	2	Nam Sand Address Scarpe 108 Vir	ginia Aven	ue: Cumber	land, MD 2	1502
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comblishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Severe Pe	ripher	er the mode of dying	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death Common S
8760,	eath certificate be executed ettending physicien and for use as the burial-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
P.O. Box 6	0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	Ectopic pregnance Other (specify)	<i>'</i>		23d. Date Mont	
	w requires that the been signed by the should be detache	by	Part II. Other significent conditions con	tributing to death but not res		nderlying cause giv	ven in Part I.	23e. Did to	_	oute to the cause of death?
Division of Vital Records,	The la ate has page 2	Completed						24a. Whas a autops perform	sy pri med? de	ere autopsy findings available or to completion of cause of ath?
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	analah.		104	•	eath (Check only or		
of	G 50	2	1 ☐ Yes 2 No ☐	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of	T 3L DOA		Home 5 Reside	ence 6 Other	
הס	en Afte	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No	200. 2000.00 11	ow, a. y	-
Divisi	of or Attending after death. I Director: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia				28f. Location (S City or Town		or Rural Route Number,
	Hospite 4 hours Funeral ely filla	edicai C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and man late and place, ar	ner as stated. Indicated the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	.2	10	29c. Licens				(Month, Day, Year)
	٤		· women	mete 1		Doo	55325	5	Feb a	23, 2006
	4		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, 48 <b>1</b>	Print) Te	race	Frostbur	g Mr	21532
*	Sta Registi		31. Date filed (Marth Pay, Year) 2000	32. Registrar's Sign	ature	and of				

Thomas E. Lloyd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item # 23a, 27, perMF, C853, 3/2/06 TI State of Maryland / Department of Health and Mental Hygiene | | | | | | 06-1148 AG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Thomas E. Lloyd February 14, 2006 4:46 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 577-80-9960 48 2/14/1958 Washington, DC Director Usuat Residence of Decedent 10a. State MD 10c. City, Town or Location Baltimore 10d. Inside City Limits "naturel", or items 23a or 28a-f ehow the Madical Examiner must be notified at 1 Yes 2 □ No Direct 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 606 West Franklin Street 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: ۾ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private Industry permit. Pages 1 end 2 should be filt Depertment of Heelth and Mental Hy Important: if item 27 is marked oth any july or other traumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnny Lloyd Lula Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Lloyd, II/Son 2132 Greenwood Dr., Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 2/20/2006 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Tyrone J. Young Funeral Services 719 Kennedy Street, NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Acquired Immuno Defiecency Syndrome **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2□No Yes 2 No : After this certifica e funeral director, f Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XYes 2 No 2XX R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) ۵ 4 Homicide within 24 hours e To the Funerai C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) February 15, 2006 O.C.M.E. in

31. Date filed (Month, Day, Year)

22

dress of person who completed cause of death (Item 23a) (Type, Print)

111 Pe 111 Penn Street, Baltimore, Maryland 2. Registrar's Signature

State

Registrar

			For Stete Registrar	State of Man		epartment Certificate			_	giene	06	06156
3	S		Decedent's Name (First, Middle, Last	)		•			2. Date of De	ath	10.50	3. Time of Death
( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	Physicia		PAULINE LORR	AINE LOR	ENSE				Month FEBRU	ARY 2	Year 22,200	06 5:45A M
120	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of Death			ounty of Deat	
1	LAGITHIT		CHARLES COUNTY	NURSING &	REHAE	B. LA	PLA	ATA			CHARI	LES
	Funeral		5. Social Security Number 6. Se	x 7. Age (/	n yrs. last birth	day) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th V Yearl	9. Birt	hplace (State or Foreign
	Director		215-36-3025	□M 2[XF 8	2 Yr	S. WIOTILIS	Days	Tiodis Iviii.	AUG.1			RGINIA
:	D .		Usual Residence of Decedent  10a, State 10b, County	11	Oc. City, Town	or Location						10d. Inside City Limits
	anyla shov	<u>_</u>										1XXes 2 No
	Ne M	Director	MARYLAND CHARL  10e. Street and Number	ES	L #	A PLATA				10a Citizo	n of What Co	luntar?
	a or	급	10200 LA PLATA	P () A D		101. 240		546			J.S.A.	•
	eath	Funerail	11. Marital Status	12. Was Decedent Eve	ar in U.S.	13 Was Deced		ispanic Origin? (Sp	ecity Yes or No		. Race - Ame	
	ther d	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X X o		If Yes, spec	ify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White	
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21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at	Completed	15. Decedent's Edi (Specify only highest grad			ecedent's Usua		ation during most of work	una	16b. Kind	of Business/	/industry
7	thin 7 an "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	7	ife. DO NOT us	e retired	)	9			
7	filed wi Hygien other th	20	10		НС	DMEMAKI	ER ,				OWN SI	ELF
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<u> </u>	should be filed within and Mental Hygiene.  marked other than umatic event, the Mental Hygiene.	ဥ	ASHBY MALONE,						E. WEAT			
Maryland	12 sho n and ris m raum		19a. Informant's Name/Relationship (T		0.5			and Number or Ru				
	s 1 and 2 should be filed within 72 hours after death with the Marylan II Health and Mental Hygiene 1. Health and Mental Hygiene 1. The Marylan Ithm 27 is marked other than "natural", or frems 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at	1	PATRICIA E. SI 20a. Method of Disposition		20h. Place of F	isposition (Nan	ne of		Date		o E / V A ution - City or	
Baltimore,	Pages Int: if it		1 Burial 2 remation 3 🗆	Removal from State	cemetery,	crematory or o	ther plac	e)			,	
Ħ	it. Partant		4 □Donation 5 □ Other (Specify)  21. Signature of Fuheral Service License			7 N CRI		CORY 2-2	23-06	ALEX	(ANDR	IA, VA
$\mathbf{B}$ a	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other <u>900.6</u> 9.		1716.	70 1	1004/19			FUNER	AL SER	VICE,	P.A	
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- 6	(E.		shock, or heart failure. List only o	one cause on each line.	i s	- 11			/			Interval Between Onset and Death
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9	ing p	Mec	IF FEMALE:									
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o.	that the death certific ed by the attending p detached for use as	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4⊡Pregnant at tin 9⊡Unknown	ne or death	5 ☐ Other (sp	ecity)		······································			
<b>Q</b>	res that t signed by	F.	Part II. Other significant conditions co	entributing to death but i	not resulting in t	he underlying c	ause give	en in Part I.	23e. Did t	obacco use	contribute to	o the cause of death?
Vital Records,	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	Hypertens	3101					1 🗆	Yes 2□	No 3 P	robably 4 Unknown
CO	w requir been s should	iete							24a. Was	an	24b. Were ar	utopsy findings available
Re	he lav e has	dmc					-			psy ormed?	prior to death?	completion of cause of
ta		a	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes	2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3 2 □ No
	S S	To B	examiner? 1 \( \sum \) Yes 2 \( \sum \) No	Hospital:	2 ER/Outp	atient 3 DC	A Oth	00 ()4	ome 5 Resi		☐Other (Spe	ecify)
0	g Physical dispersion		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Tii	me of 2	Bc. Injun	v at	28d. Describe			
Ö	andir path. pr: Af he fur	atic	2 Accident investigation			М		Yes 2 □ No				
Division of	r Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farr (Specify)	n, street, factory	, office		28f. Location ( City or To		Number or R	ural Route Number,
	urs af rai D											
	Hosp 14 hor Fune fely fi	edicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of exiner: On the basis of ex	my knowledge, xamination and	death occurred or investigation	at the tin , in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	date and p	nd manner as lace, and due	s stated. e to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	29b. Signature and title of certifier	and manner state	u.			e number				th, Day, Year)
	₹ ¥ ₹ 8		1 Alun	se.	MO		06	5540	55	21	173	106
	0		30. Name and address of person who d	completed cause of doc	th (Item 22s) /T	Vne Print\	1		,	1	00/	1 = 01=1
	3		Ending Hus	SSEIN	(h)	-104 C	- A	Outain	a R	loh.	ah	LaPlata
	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's	s Signature	9 40 -		- 111	7	15-110	4 <b>U</b>	, C.
	Registr		MAR 0 1 2008	Medica	N. As	and the						

			State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa Per FH G853 3/15/06	rtment of Health and Me lifficate of Death	ental Hygie	ne 006	06157
	Dhuaisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		RUSSELL EUGENE MC KENZIE		FËBRUAR	Y 19,20	06 8:38PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			3000 GALLERY PL., APT. T-3	WALDORF		CHAR	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	B. Date of Bi <b>k()</b> — (Month, Day, Ye OCT • 20 ,		hplace (State or Foreign buntry) RYLAND
	pu »		Usuaf Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	antion			104 1-14-01-11-11
	sho	'n		Sation			10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	he M	Director	MARYLAND CHARLES WALDORF  10e. Street and Number	10f. Zip Code	140-	C'': (1111 1 C	••
	with 1			·	10g.	Citizen of What Co	·
	eath	erai	3000 GALLERY PLACE, APT. T-3  11. Marital Status  12. Was Decedent Ever in U.S. 13. V	20602 Vas Decedent of Hispanic Origin? (Spec	ify Yes or No.	U.S.A.	
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. Ind other than "natural; or Items 23e or 28e-f show event, the Medical Evanicer must be notified at	by Funeral	Armed Forces? If	Yes, specify Cuban, Mexican, Puerto R  Yes 212 No Specify:	ican, etc.)	Black, White	
Ö	2 hou	ted	15. Decedent's Education 16a. Deced	ent's Usual Occupation	166	o. Kind of Business/	Industry
215	within 7, ene. than "n ht Medi	pie	(Specify only highest grade completed) (Give iiife. Life. Li	kind of work done during most of working OO NOT use retired)	7		•
21	d with giene er the	Completed		ENTER	c	ONTRACT	ING CO.
P	al Hy foth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	First, Middle, Mai	den Sumame)	
Va	Ment Ment arkec	To	HENRY LEONARD MC KENZIE	PEARL ES	STELLE	SMITH	
, Maryland	es 1 and 2 should be filed within of Health and Mental Hygiene f item 27 is marked other than " " r other traumatic event, the Mec			g Address (Street and Number or Rural STONE AVE., WALI			
Baltimore,	Pages 1 ar nent of Hea int: If item : iry or other		1 Li Buriai 2 Li Fremation 3 Li Hemovai from State	natory or other place)		Location - City or	
亞			4 □ Donation 5 □ Other (Specify) METROPOLITIAN  21. Signature of Frontial Service Licensee MQO 479  22.	CREMATORY   2-22- Name and Address of Facility	-06 AL	EXANDRIA	A, VA
Ba	permit. Departrimports any injit		mul of	RAYMOND FUNÉRAL			
	2		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	A PLATA, MARYLA or the mode of dying, such as cardiac or	respiratory arrest,	40	Approximate Interval Between
h	f frysician		Immediate Cause (Final disease or condition	weaver Dia			Onset and Death
	/Medical		resulting in death)  a.  Due to (or as a consequence of):	000000000000000000000000000000000000000			3 412
	Examiner		Sequentially list conditions, b.				
	D #	iner	if any, feading to immediate cause. Einer Underwing Cause (Disease or injury				
	ecute and -trans	Examiner	that initiated events c.				
60,	icate be executed physician and s the burial-transit		Due to (or as a consequence of):				
68760,	phys the	edicai	d				
Box (			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	ivery
ă	death certi e attending od for use a	Physician/M	in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
0	at the de by the a tached	hys	9 □ Unknown				
S, P	es tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ğ	w require been sii should t		Schripplishea - & drug	induced playeuron	1 🗌 Yes	2 □ No 3 □ Pro	obably 4 12 Unknown
of Vital Records,	a s c	Completed	/		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>m</u>		Com			performed	death?	2 No
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (	Check only one)		
<u></u>	Physic this o	2	1  Yes 2 No 1  Inpatient 2  ER/Outpatient	3 □ DOA Other: 4 □ Nursing Home	e 517 Pesidence	e 6 □Other (Spec	cify)
	ding P h. After t funera	on:	27. Maring of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	ld. Describe how i	njury occurred	
Sio	Mtendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	(1)		
Division	or /	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office	City or Town, S.	t and Number or Ru tate)	irai Houte Number,
_	pours cours seral		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death	occurred at the time, date and place, an	d due to the cause	e(s) and manner as	stated
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical	(Check only one) Medicel Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred	at the time, date	and place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	h, Day, Year)
)			· Callida	1/029 1		22	0-06
	1		30 Name and address of person who completed cause of death (Item 23a) (Type, F		, , , ;		1 04 700
	1		HOWELL, Danie 11345, F	dem brooke sc	1 104	Walder	7, MD
'A'	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Shature				
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			For State 2-24-06 Ameno Ameno American		f Marylan PerFH PCC Phys.PCC							giene	06	0615	8
	Physici		Decedent's Name (First, Middle,     JACQUELINE	Last)	MCCAR						2. Date of Dea Month FEBRUA	ath	2006	3. Time of De 6:12P	eath M
	/Medic Examin	_	4a. Fecility Name (If not institution, WASHINGTON ADV				4b. City, TAKOM		Location o	of Death			ounty of Death	Z	
N. Carlo	Funeral Director		127-40-3948	6. Sex 1 □ M 2 1 1 F	7. Age (In yrs. 56	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birth (Month, Day DECEMB			olace (State or F ntry) YORK	₹oreign
	Maryland I-f ahow	tor	Usual Residence of Decedent  10a. State 10b. County  MD PRINCE	GEORGE'S		y, Town or Lo								10d. Inside City	
	with the	i Director	10e. Street and Number 3403 NEWTON S	TREET			10f. Zip 20	Code 712				10g. Citize	n of What Cou A .	ntry?	
980	72 hours after death with the Maryland Insture!, or Itema 23s or 28s-f show Incel Exacultier cust be notified a	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2X No ve		Was Deced If Yes, spec			gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)		Race - Amen Black, White, pecify:		
21215-0036	within ene. then	Completed	15. Decedent (Specify only highes: Elementary/Secondary (0·12) 12th	s Education grade completed) College (		(Give	dent's Usua kind of wor DO NOT us	k done d e retired,	luring most )			dustry			
Maryland 2	be filed stal Hyg ad other avant,	To Be C	17. Father's Name (First, Middle, L ARTHUR A. ST						18. Mothe	LY M	(First, Middle,	Maiden St			
	12 sh hand hand 7 is m traum		ANTOINIE MCCA	ip (Type, Print) RTHY/DAUC	SHTER		_				RAINER,				
Baltimore,	5 to L		20a. Method of Disposition  1X Burial 2 Cremation 4 Donation 5 Other (Sp.		State 20b. P	Place of Disposers of SUCKE	osition (Nam matory or of CEMET	ne of ther place ERT	tery	2-20 2/18/	ate )=06 <del>2006</del>	20c, Lpca Clin LAND	tion - City or T ton, MC OVER, MA	wn, State	
Balt	permit. Pag Department Important: f any Injury o		21. Signature of Funeral Service L	icenspe — La Cl	1						B. JENI LANDOVI			20785	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that conty one cause on a	caused the death	h. Do not en	ter the mode	e of dying	g, such as	cardiac o	r respiratory ari	rest,		Approximate Interval Betwe Onset and De	
4	/Medical Examiner sicien and prival-fransif	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a conseq (or as a conseq	uence of):  Movuence of):  U	J J	the	per	tear	men				
8760,	2 2 9	cai	resulting in death) Last	d. Due to	(or as a conseq MB	l $\mathcal{D}$	03	en	th	<b>y</b>					
.O. Box 68	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	1 Live I	itcome of pregna birth 2 ☐ Feta nant at time of d	I death 3[	∃Ectopic pro					23	d. Date of deliv Month	er <b>y</b> Day Yea	ar
۵.	signed signed d be de	þ	Part II. Other significant conditio	ns contributing to d	leath but not res	ulting in the t	inderlying ca	ause give	an in Part I.		23e. Did to			he cause of dea	
al Records,		Completed									24a. Was a autop perfor 1 🗆 Yes	sy	24b. Were auto prior to co death? 1 \(\sum \) Yes	ppsy findings avonpletion of cau	ailable ise of
f Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1	npatient 2	ER/Outpatie	nt 3□ DO	A Othe	ac-		Check only on		☐Other (Speci	(y)	
Division of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	of Injury oth, Day Year)	28b. Time of Injury	of 2	8c. injury Work	vat k? Yes 2 □ I		28d. Describe h				
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	To the Hospital or within 24 hours after To the Funeral Direction plate of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Puneral Direction	edical	(Check only 2 Medical 8 one)	g Physician: To the examiner: On the band man	e best of my kno casis of examina nner stated.	owledge, dea attion and/or in	rvestigation,	in my of	pinion, dea	d place, a th occurre	ed at the time, o	date and p	lace, and due t	o the cause(s)	
	To the within 2 To the complet	2	29b. Signature and title of certifier Shum	Tre			1	046	e number	8			signed (Month, oruary	Dey, Year)	>
P	- M		30. Name and address of person of Stuum	Tel M	n 3	n 23a) (Type	Print)	rd to	n	8-/	Hynte	bull	6 mr	2078	7
4	Sta Registi		31. Date filed (Month, Day, Year) FFB 1 5 206	6 Sept.	Registrar's Signa	A STATE OF					0				

		1	For State Registrar	State of Maryland	•	artment tificate			nd M	ental H	ygier Reg.	41116	(	06159
Phys	siciai		1. Decedent's Name (First, Middle, Last)  Ruby P. Mathers							2. Date of Month Feb.		Day Y	ear	3. Time of Death 8:00 p M
	edica mine		4a. Facility Name (If not institution, give si	reet and number)		4b. City, T	own, or L	ocation of		1001		4c. County of	Death	0.00 p
LAG	£ %		3710 Shepherd Stre	eet		Br	entwo	boc				Princ	e G	eorge's
Fune Direct			234 32 3200	7. Age (In yrs. le	ast birthday) Yrs.	If Under Months	Days Days	If Under 2 Hours	Min.	8. Date of (Month, Oct.	Birth Day, Ye. 16,	<sup>ar)</sup> 1926 W	Birthp Cour est	olace (State or Foreign otry) Virginia
and	4	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation							1	0d. Inside City Limits
Maryl -1 ehc		Ö	Maryland Prince Ge	eorge's B	rentwo	od								1 ▼ Yes 2 No
h the		Lec	10e. Street and Number			10f. Zip	Code				10g.	Citizen of Wha	at Cour	ntry?
th wit		<u>a</u>	3710 Shepherd Stree	et			20	722				USA		
DESIGNATION CE, INTERTY INTO A 12 13-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other then "natural", or fleme 23s or 28s-1 show any Interty or the trainmails event the Medical Exercipation and the profiled at		2	11. Marital Status 1  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	4	Was Decede If Yes, speci 1 ☐ Yes 2			gin? (Spe , Puerto f	cify Yes or Rican, etc.)	No-	14. Race - Black, Specify:	White,	
A I A I D-UUSO Id within 72 hours af giene. er then "natural", or		Completed by	15. Decedent's Educ		16a. Dece	dent's Usual	Occupat	tion	of working	10	16b	. Kind of Busir	ness/In	dustry
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led wi		် ၁	3		S	ales A	7			/Cinch hairle			Co/	Retail
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Maryland of 2 should be file lith and Mental Hy 27 le marked oth	l latti	<u> </u>	Walter Grey Richa  19a. Informant's Name/Relationship (Type		19b. Mailii	na Address	(Street au			ngler	nber. Cit	y or Town, Sta	ate. Zic	(Code)
Mich and 2 s Lith and 27 to 27			Mr. Sandy Alfred Do			Shepl	,					•		,
s 1 ar if Hea item		+	20a. Method of Disposition	C	ace of Dispo	sition (Nam	e of			ate	<del></del>	Location - Ci	ty or To	own, State
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Physici	an		23a. Part 1. Enter the disease, or shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						r respirator				Approximate Interval Between Onset and Death
/Media	cal	4	disease or condition resulting in death)	Due to (or as a consequence of the consequence of t	uence of):	ν <u>-</u>		ردمد					+	
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3 / 6U, ate be executed hysician and he burial transit	al-Itan	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):								+	
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rds quires in sign	90 91		Enrphyse	na			_	<u> </u>		1.	☐ Yes	2 □ No 3	☐ Prot	pably 4 planknown
VITAL RECORDS, sician: The law requires to entiticate has been signs	ous z	plete	Malnu	Tri Iio w						24a. W		24b. We	re auto	psy findings available mpletion of cause of
The lav	oage	Completed						-		pe	itopsy informed s 2 🗔	l? dea	ath?	21) Mo
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DIVISION OF To the Hospital or Attending Phy within 24 hours after death. To the Fundral Director: After thi	ad in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory	, office		4		n (Stree Town, S		or Rura	al Route Number,
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To the within 2.	E 00	Σ	29b. Signature and title of certifier			290	. License	number				Date signed (	Month,	Day, Year)
			Mehow Ma	sen mor			Do	5057	4		2	110/06		
18)			30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type	, Print)	<i>a</i>	0.	- T.	2 .	-			
0	Stai	0	MEHRU MASTER, 31. Date filed (Month, Day, Year)  FEB 1 4 2006	MIS, 6570 K	enilu	enth	ani	, su	link	dito	VZ	BUUS	+37	
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State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Pay 8, 2006 Physician 8:00 P.M Charles S. Martin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Capitol Heights 4719 Fable Street If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours XXM 2□F 66 Director 254-60-4360 1/11/40 Georgia Usual Residence of Decedent with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits Show me 23a or 28a-f show 1√ Yes 2 No Director Capitol Heights Md. P.G. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20743 U.S.A. 4719 Fable Street death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 27 is marked other then "naturel", or item traumatic event, the Nedical Examinat Black, White, etc. ☐Yes 2 XNo f Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Pipe Technician Water /Sewer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental Hi fitem 27 ie marked oth r other traumatic even Be U.S. Martin Addie Bell Martin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4719 Fable St., Capitol Hgts., Md. 20743 Sharon Williams Martin/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of hant: if ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 2/14/06 Beltsville, Md. permit. Pag Department important: f eny injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility & Sons Co., Inc. SAOW 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PRONCHOGENIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown Ś signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Anemia 24a. Was an cate hes t certificate 1 Yes 2 No Be ( funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural Injun 5 Pending 1 □ Yes 2 □ No nvestigation 2 Accident i Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerel 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D29671 2/10/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6501 Landover Road, Cheverly, Maryland 20785 Villamor S. Reyes, M.D. 31. Date filed (Month, Day, Year) B2. Registrar's Signal State Registrar FEB 1 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 16:16 P<sup>M</sup> 02 12 06 David Murphy, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XM 2□ F Director 418-66-0613 4 48 AL Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?? is marked other then "naturel", or iteme 23a or 28a-f ehow traumatic event, the Mudical Exeminar must be notified at 1₽Yes 2□No Director MD Prince Georges Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4820 Homer Avenue 20746 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important; if tem 27 is marked other then "naturel", or item any injury or other traumatic event, the Mudical Experiment Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Specify: Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Claretta Ely David Murphy, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4820 Homer Avenue, Suitland, MD 20746 Mildred D. Murphy/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 02-20-06 Suitland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Road, Camp Springs, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence off: Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 donknown HYPERCHOLESTEROLEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has performed 2□ No 2 No 1 TYes To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pres 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Euneral Dire
 Funeral Dire
 Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JOO.24 D 40324 FEBRUARY 13, 2006 address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD, CLINTON, MARYLAND 20735 JODRIE, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Bearing & Speck

DHMH 17 Rev 1/2001

ORIGINAL

Phys	ician	1 - State Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.  2. Date of Death Month Da	year  3. Time of Death
	dical	Brawley Miller  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		13 2006 5. 40 PM c. County of Death
Funera Directo		Poctor's Community Hospital         5. Social Security Number       6. Sex       7. Age (In yrs. last         700−16−9392       1 → 2 □ F       92	birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year May 3, 191	Prince Georges  9. Birthplace (State or Foreig Country) Clinton, S.C.
yland how Lat		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limit
Ba-1 s	cto		hington		1 X Yes 2 N
with the	Dire	10e. Street and Number 1224 46th Street S.E.	10f. Zip Code 20019		itizen of What Country? Inited States
72 hours after death with the Maryland natural; or Items 23e or 28e-1 show lice! Executed to interest the motified at	by Funeral Director	11. Marital Status  1	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.  Specify: Black
within ne.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+	Decedent's Usual Occupation     (Give kind of work done during most of work life. DO NOT use retired)  Accountant	king	Kind of Business/Industry
d oth	Be	17. Father's Name (First, Middle, Last)  David Pickens Miller		ne (First, Middle, Maide a Hunter	n Sumame)
s 1 and 2 should be filed v f Health and Mental Hygie Itsm 27 is marked other i other traumatic svent, iii	ပ္	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru 1224 46th St. S.E. Wa	ral Route Number, City	
Heal Heal		1 Bunal 2 XCremation 3 Hemoval from State	e of Disposition (Name of etery, crematory or other place) copolitan Feb.		ocation - City or Town, State
permit. Pages Department of importsnt: if it sny injury or o	Suc	21. Signature of Funeral Service Licensee  Authorizer M 01 005	22 Name and Address of Facility 22 Name and Address of Facility 3538 Mariboro Pik		
Medicate be executed with the property of physician and as the burial-transit	al er ক	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ce of):	ihus	Onset and Death
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
quires that the or signed by the	2	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.		use contribute to the cause of death?  2 MNo 3 Probably 4 Unknow
Physician: The law requires tribis certificate has been signeral director, page 2 should be or	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Physician: this certifica	Be (	25. Was case referred to medical examiner?		ith (Check only one)	
ding Physia. A. After this of funeral dir	on: To		lb. Time of 28c. Injury at Nork?	ome 5 Residence 28d. Describe how in	
or Attendition of Attendition death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No e, farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
To the Hospital within 24 hours a To the Funeral Completely filled	edicai C	29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the best of my knowle 2 ☐ Medical Examiner: On the basis of examination and manner stated.			
To the To the comple	11	29b. Signalere and the of certifier	29c. License number		ate signed (Month, Day, Year)
(15) (	Va	30. Name and address of person who completed cause of death (Item 20)	Ba) (Type, Print)  EX (N, 124	Bonio	nD 20717
in the second	State	31. Date filed (Month, Day, Year)  7. Registrar's Signatur			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 7, 2006 **Physician** Minnie J. McDonald 4:15p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2₩F 261-42-1227 81 Yrs Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location ir than "natural", or itame 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits Maryland Prince George 1 X Yes 2 No Director Clinton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 A No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) 4th Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Dapartment of Health and Mental I Important: If Item 27 Is marked o James Rogers Emma Rogers ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minnie Bacote/Daughter 3938 Suitland Rd. #202; Suitland, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection cemetery Feb. 11,2006 Clinton, MD. Pone Funeral Homes 5538 Mariboro Pike 21. Signature of Tyneral Service Licenses 22. Name and Address of Facility Forestville, MD. 20747 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) menmonia **Physician** /Medical Due to (or as a consequence of): Candis Vasalon niscan Examiner ATheroscleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as tha IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No Division of Vital 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1. Natural Injury 5 Pending aftar death. М 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours aftar To the Funeral Direct 4 Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D'A DX5365 02-3-2008 1/70/ /ivingston RU # 10/ For washington MD 22076 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nichal Sidaneus, mn 31. Date filed (Month, Day, Year) 2. Registrar's Signature FEB 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Physician Betty M. McMeekin February 10, 2006 5:41 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F 72 Director Dec 3, 1933 Washington, DC 579-42-3891 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 le marked other than "natural", or Itame 23a or 28a-f show other traumatic event. The Modical Exeminer must be notified at Maryland Prince Georges Yes 2 No Brandywine, Maryland Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11903 Lusbys Lane 20613 United States death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene Important: If item 27 ie marked other than "natural", or Itam any Injury or other traumatic event. If a Medical Examinar's ORCE. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George D. Chichester Bessie Blackwell 19a. Informant's Name/Relationship (Type, Print)

Fatima McClearn/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14505 Duckett Road, Brandywine, MD 20613 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 2/15/06 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes, P.A. DERU 5538 Marlboro Pike, Forestville, MD 20747 Approximate Interval Between Onset and Death 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final VENTRICULAR FIBRILLATION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Admitted on Examiner CARDIOMYOPATHY 02/09/06 DILATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Expired on Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed 02/10/06 Due to (or as a consequence of) AT Division of Vital Records, P.O. Box 68760, 5.41 PM Physician/Medical IF FEMALE: 23c. If yes, oulcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig. , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 2 1 No 1 Yes After.

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the funeral director, p Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide efter Dire 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the Complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35 295 02/13/06 mount 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUMANI, 10 ST. PATRICKS DRIVE, SUICE 208, WALDORF, MD 20603 SATISH 31. Date filed (Month, Day, Year) State Registrar

# Amended Items 20b & 20c per F.D. 02/14/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** 11:30 am 2006 Elizabeth Louise Mechalske /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Finksburg 2008 Suffolk Road If Under 1 Year If Under 24 Hrs.

Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 DEF PA 75 213-28-1674 Director January 13 1931 Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 7 is marked other than "netural", or items 23a or 28a-f show traumatic event, it e Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Finksburg MD Carroll 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21048 USA 2008 Suffolk Road Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc filed within 72 hours after ☐ Yes 2 No Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fill if Health and Mental Histem 27 is marked oth Be Betty Tomlin Wayne Breslin, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Suffolk Road Finksburg, MD 21048 Richard Mechalske/husband other t item 29b Place of Disposition (Name of Smither place) 20a. Method of Disposition 20c. Balierifile Lown, Mp Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Pk 2/16/2006 permit. Page Department o Importent: If any injury or once. ō Sykesville, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ingral Service Licensee <sup>2</sup>Prints Fundially Home and Chapel, P.A. all 412 Washington Road Westminster, MD 21157 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Slave Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 | NO Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi 27. Mann I f Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Alatural 5 Pending 1 □ Yes 2 □ No within 24 ours after death.

To the Funeral Director A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 39502 MM 1ou 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Westwester MBZIIST Maen (+ 44 32. Registar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of M	aryland /		rtment <i>tificate</i>				lental	Hygie Reg.	7 111	36	06166
- 3	. A.		Decedent's Name (First, Middle, Las	)							2. Date of	of Death			3. Time of Death
Cont.	Physicia /Medic		Ardith Maxine Muri	cay							Month O2		Day	O6	4:55 AM
)	Examin	-01	4a. Facility Name (If not institution, give Sacred Hear	1 (1 )	1 - 1		4b. City, T	own, or l	1	and			all	y of Death	ny
	Funeral Director		200 12 0405	х 7. Ag	pe (In yrs. last 85	Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Montile) Aug.	of Birth Day, Ye 12,	1920	9. Birthp Cour Penn	place (State or Foreign ntry) Sylvania
	tand tand		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							1	10d. Inside City Limits
	Mary Firsh	to	PA Somerse		Salis	sbury									1 X Yes 2 ☐ No
	or 28s	lrec	10e. Street and Number				10f. Zip (	Code				10g.	. Citizen of	What Cour	ntry?
	23a c	ral	178 Beachy Avenue				1555	58				U	SA		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, the Medical Exact fast must be notified at ODGe.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	,		Was Decede f Yes, specif I □ Yes 2	fy Cuban	panic Ori , Mexicai Specify:	n, Puerto	ecify Yes o Rican, etc	or No- .)		ce - Americ ck, White, fy: Whi	etc.
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2	han han	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) <b>L</b>	lite. Homem	kind of work	e retired)				_	17 -		
12	Hygier ther the		12 17. Father's Name (First, Middle, Last)			10mem	aver		18 Moth	er's Name	e (First. M		wn Ho		
ano	d be f	o Be	Hubert E. Miller								Pol			,	
Σ	shoul nd Me mark	우	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	g Address	(Street ar					ity or Town	, State, Zip	o Code)
ž	alth a 27 is		Bonnie Lishia/Daug	hter		199	Smith	Ave	., Sa	alisk	oury,	PA	1555	8	
Baltimore,	Pages 1 anneal of He		20a. Method of Disposition  1 Burial 2 Cernation 3 4 Donation 5 Other (Specify		cem	etery, crer	sition (Naminatory or oth	her place,	1		) ate		c. Location		own, State
Balti	permit. Departn Imports any Inju		21. Signature of Funeral Service Licen	nou		22	. Name and	Address	of Facili	ty Nev	man	Fune	cal H		
	*		23a. Part1. Enfer the disease, or comp shock, or heart failure. List only	lications that cause one cause on each I	d the death. I										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, SEVI		Ao	RTIC		TE	NOS	15				Onset and Death
185	/Medical Examiner		resulting in death)	4	a consequen		7-77-								or year.
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			PAUL T. LIVENGOOD  31. Date filed (Month, Day, Year)		SETOI trar's Signatur		, ci	ame	ER	LITIV	א ט	עי	2150	12	-
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			1 - For State Registrar	State of	Maryland	-		nt of H			ental Hygio	ene 06		) 6 l	67
	Physici	an	Decedent's Name (First, Middle, Last			_					Date of Death Month	Day Y	'ear	3. Time	of Death
	/Medic		Paul Willia		Miller,	Sr.	1				February	11, 20		2:15	A M
	Examin	er	4a. Facility Name (If not institution, given 900 Spruce Circ)		oer)		4b. Cit	y, Town, or	Location of			4c. County of	_	·	
	<b>5</b>		5. Social Security Number 6. S		. Age (In yrs. Ia	ist birthday	If Und	er 1 Year	If Under:	-	8 Date of Birth			rett	or Foreign
	Funeral Director			<b>⊠</b> M 2□F	76	Yrs.	Month		Hours	Min.	8. Date of Birth (Month, Day, )				or Foreign
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	show	_	10a. State 10b. County		10c. City	Town or L	ocation							10d. Inside	
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	with ti	吉	10e. Street and Number				10f. Z	ip Code			10	g. Citizen of Wh	at Cou	ntry?	
	eath 1s 23	by Funeral Director	900 Spruce Circle  11. Marital Status	12. Was Deced	ent Ever in II 9	13	Was Dec		21550		city Voc or No-	USA 14. Race -	Amori	can Indian	
	ter d	E	1 Never Married 2 X Married	Armed Force	es?	, 10.	If Yes, sp	ecify Cuba	n, Mexican	i, Puerto F	cify Yes or No- Rican, etc.)		White,		
ğ	al', o	<u>\$</u>	3 ☐ Widowed 4 ☐ Divorced	If Vac Give	es: Korea	n	1 Tes	2 <b>X</b> No	Specify:			Specify:	Wh	ite	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or Items 23a or 28a-f show any injury or other traumatic event, Item Medical Exaction at most be notified at another.	ှ	19a. Informant's Name/Relationship		iller	19b Maili	ina Addre	ss (Street a		iisa ororBum	C. I Route Number,	Kuch			
<u>8</u>	od 2 s Ith ar 27 is r trau		Elizabeth A. Mil		e						kland, M			, 0000)	
ē,	s 1 a/r f Hea item other		20a. Method of Disposition	•	20b. Pla	ace of Disp	osition //	ame of				Oc. Location - Ci		own, State	
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,09/80	Attending Physician: The law requires that the death certificate be executed refath. reath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	ras a consequ	ence of):									-
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	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 M Certifying Ph (Check only one) 2 Medical Exer	y <b>sicien:</b> To the b niner: On the bas and manne	is of examinati	rledge, deat on and/or in	rvestigatio	on, in my op	oinion, deal	d place, a th occurre	ed at the time, dat	e and place, and	d due to	the cause	
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			MINT	There	-	MI	2	D002	5/59		F	ebruary	11	, 2006	<b>)</b>
21	+VA		30. Name and address of person who Walter K. Nauma	nn, M.D.	, PO B	ox 24		ccide	nt MD	215	20				
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 4		pistrar's Signati		Aven	K a							

			For State Registrar	State of Mary		artment of F		-	giene	106	0611	5.8
	Physici /Medio	al	1. Decedent's Name (First, Middle	anokey			r Location of Dea	2. Date of De Month February	Day	Year 2006 ounty of Death	3. Time of E	
	Examin Funeral Director	er	University of  5. Social Security Number  N/A	Maryland	n yrs. last birthday) Yrs.	Boult 1 Year Months Days	If Under 24 Hrs	S. 8. Date of Birt	h v. Year)	9. Birthp	place (State or ntry) vland	Foreign
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Dorch		Oc. City, Town or Lo				9		10d. Inside City	
036	be filed within 72 hours after death with the Maryland tal Hyglene d other than "naturel", or Itama 23a or 28a-f show event, tra Madical Everting misst be resilited at	by Funeral Directo	10e. Street and Number  563 Greenwood  11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	Ave .  12. Was Decedent Eve Armed Forces?	or in U.S. 13.	10f. Zip Code  21613 Was Decedent of H If Yes, specify Cuba	dispanic Origin? ( an, Mexican, Puei Specify:		USA 14	en of What Could Race - Americ Black, White, Specify:	can Indian,	
121215-0036	filed within 72 hou Hygiene. other than "natura ent, tre Madice E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, I	t grade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo		neve	of Business/In	dustry	
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Balti	Departic		21. Signature of Funeral Service to Commic 23a. Part1. Enter the disease, or	4. Shaw	22	Name and Addre Bennie S 524 Race	ss of Facility Mith Fun Street, C	eral Hom ambridge	e ,Mary			
8/60,	Certificate be executed  Medical Industrians and Industrians Indus	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsilone cause on each line.  a. Due to (or as a complete comp	me Pronsequence of):	remoti	nrity			5	Interval Betw Onset and D	
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			For State Registrar		State of M	larylan	-	artment rtificate			and M	ental Hy	giene Reg. No.	06	06169	
	Physici		1. Decedent's Nam Floyd I	e (First, Middle, R. Metzo	,							2. Date of De Month Feb.	Bath Bay	2006	3. Time of Death 11:00p M	
	/Medio Examin		4a. Facility Name (	If not institution,	give street and number	-)		4b. City, 1	Town, or	Location o	of Death			ounty of Dea	th	
			52 Aru	ndel Bea	ich Road				S	evern		rk		Anne	Arundel	
	Funeral Director		5. Social Security N 506-20-	7788	5. Sex 7. A 1 🕱 M 2 □ F	ge (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bi (Month, D. Mar. 2	rth ay, Year) 27, 19	9. Bir Cc	thplace (State or Foreign buntry) SD	
	and		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
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	h with th	al Dire	10e. Street and Nu 52 Arur		ich Road			10f. Zip		21146			10g. Citize	on of What Co USA	ountry?	
920	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mertal Hygiene. Department of Heelih and Mertal Hygiene. I proportent: If Item 27 is marked other then "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinat must be notified at ODGs.	by Funeral Director	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2 <b>⊠</b> Marrie 4 □Divorced	12. Was Deceden Armed Forces d 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	? ]No <b>W</b> W	7T T	Was Decede If Yes, speci 1 Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	i	Race - Ame Black, White Specify:		
21215-0036	within 72 ho ene. then "natur he Medical	Completed	(Spec		s Education grade completed) College (1-4or	5+)	(Give	dent's Usual kind of work DO NOT use uidance	k done d e retired)	uring most		ng	Seve	erna Pana Pana School	ark	
Maryland 2	ould be filed Mental Hygi arked other atic event,	To Be C	17. Father's Name Gottlik	(First, Middle, L De J. Me	ast)							(First, Middle H. Spe:		umame)		
Mar	nd 2 sho eith and 27 is ma or trauma		19a. Informant's N	ame/Relationsh a Metzge				-			Road	, Seve:				
Baltimore,	Pages 1 e ment of Her ant: If Item ury or othe			•	3 □Removal from State	.   0	lace of Dispo emetery, crei oury U	matory or oti	her place	ry	Feb. <sup>D</sup>	14, 006		ation - City or old, M		
Balt	permit. Depart Import any Inj once.		21. Signature of F	ineral Service L	EALL	d	B 4:	arranc 95 Gov	Address O &	s sons itchi	P. P. A	A. Seve	erna 1 erna 1	Park Fi	uneral Home MD 21146	
	Physician		shock, or hea Immediate Cause disease or condition	utfailure. List o (Final on	complications that cause only one cause on each	ed the death line.	h. Do not ent		7		>		arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)  Sequentially list co		Due to (or a	a. Due to (or as a consequence of):  b. Due to for as a consequence of										
3760,	that the death certificate be executed of by the attending physicien and detached for use as the burial-transit	ical Examiner	Sequentially list of it any, leading to it cause. Enter Unid Cause (Disease or that initiated event resulting in death)	injury s	c. Due to (or a	s a consequ	uence of):									
89	ntifica ng ph as th		IF FEMALE:													
P.O. Box	the death certifica y the attending ph iched for use as th	Physician/Med	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months? □No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3□	Ectopic pre Other (spe					23	d. Date of de Month	livery Day Year	
Ś	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	þ	Part II. Other signi	ficant condition	s contributing to death	but not resu	ulting in the u	nderlying ca	iuse give	n in Part I.		1	tobacco use		o the cause of death?	
of Vital Record	ysiclan: The law re is certilicate has be director, page 2 sh	Completed								_		24a. Was auto perfe 1 Yes		prior to death?	utopsy findings available completion of cause of 2 \( \sum \) No	
Vita	iclan certifi ector	Be	25. Was case reference examiner?		Hospital:				Othe			(Check only				
ot	Phys this ral dir	. To	1 Yes 2 2		1 ☐ Inpat 28a. Date of Inj		ER/Outpatier 28b. Time of		A Culd	4   Nu		ne 5 🗹 Res 8d. Describe			city)	
Division	Attending Fir deeth.	Certification:	1 ☑Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investiga 6 Could no determin	(Month, D	ay Year)	Injury	М	1   Y	? ′es 2 □ f	No	8f. Location (	Street and		ural Route Number,	
ă	pital or ours efter erel Dire	i Cert	4  Homicide		building, e	t of my kno		o conversed a	t the tim	o dato and	d place a		wn, State)	nd mannor a	a state d	
	To the Hospital or Attent within 24 hours effer deet To the Funeral Director: completely filled in by the	Medical	(Check only one)	2 Medical E	xaminer: On the basis and manners	of examinal	tion and/or in	vestigation,	in my op	inion, deat	th occurre	ed at the time,	, date and p	lace, and due	e to the cause(s)	
	Wit To	-	29b. Signature and	Curle of certifier	in Han	· · ·	240			330			2/	9/06	h, Day, Year)	
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N.	Sta Registr		31. Date filed (Mor	B 1 3 2		trar's Signa	iture	well)						-		

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar			of Ma	ryland /	-	artment tificate					Reg. N	UU	6	061	70
Physicia /Medic Examin	al	1. Decedent's Name Refricio 4a. Facility Name (III	not institution	Mantza n, give street and	mumber)	( 46	s. L (	4b. City, 1	-	Location of	of Death	2. Date of Month	b. 1	0,0	Year OO6 of Death	3. Time of 3//5	Death
Funeral Director		5. Social Security N 577 56 6 Usual Residence of	umber 793	6-8ex 1□M 2√2	7. Age	(In yrs. last)	birthday) Yrs.	If Under		If Under Hours	Min.		Day, Year	-)		olace (State ontry)	
-f show lied at	tor	10a. State Maryland	10b. County	gomery		10c. City, To Silve					-				1	10d. Inside Ci 1 ☐ Yes	
r 28a	Irec	10e. Street and Nur	mber					10f. Zip	Code				10g. C	itizen of \	What Cou	ntry?	
23a o	ai D	1000 Wind	mill L	ane				2	2090	5				USA			
jiene. r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ned 1 7	Decedent Evit Forces?  es 2 No. Give  or Dates:		1		ent of Hi fy Cuba			cify Yes or Rican, etc.)	No-	14. Rac	ck, White,	can Indian, etc. ite	
ine. Than "natu	mpletec	Elementary/Seco	ify only highe	t's Education st grade complete Colleg	ed) ge (1-4or 5+		(Give	dent's Usual kind of wor DO NOT us	k done d e retired,	lu <i>ring m</i> os )	t of worki	ng	16b.	Kind of B	usiness/In	dustry	
od othe	To Be Co	12 17. Father's Name (						Man	age	18. Mothe		(First, Mide	dle, Maide	<b>rini</b> n Suman	ty M	<del>ission</del>	S
and Me is mari		19a. Informant's Na	ame/Relations	hip (Type, Print)		1.0		•	•			i Route Nui	-				
Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic once.		Nicki M.  20a. Method of Disparation 2    4 □ Donation  21. Signature of Fu	oosition Cremation 5 Other (S	3 □Removal fr		20b. Place ceme	of Dispondery, crem	sition (Naminatory or other leaven) 2. Name and	e of her place Cend Addres	neter s of Facili	y 2/	15/200 es Rij	20c. I D6 Si Daldi	lver Fun	Sprieral	and 21 own, State ing, Ma Home MD 20	ary
xa xa xa xa xa xa xa xa xa xa xa xa xa x	edical Examiner	disease or condition resulting in death)  Sequentially list configure in the cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, nmediate rrlying njury	b. Due	to (or as a	consequence consequence consequence	s,t,ve be of):	B	ge fe	rom,	ç					7 119	7
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certificate has be rector, page 2 sh	Completed	Type 2 &	F.hr. 1	ofing	12, KG	spira	160-7	Fa	100			1 ☐ Ye	utopsy erformed? s 2 1		Were auto prior to co death? 1  Yes	opsy findings ompletion of c	availa ause
rthis raldi	on: To Be	25. Was case refer examiner?  1  Yes 2 2  27. Manner of Deat  1 Natural	No	Hospital: 1	Inpatientate of Injury		Outpatier b. Time o		A Othe Bc. Injury Work	er: 4□Ni	ursing Ho		esidence	ce 6 Other (Specify)			
after death Director: in by the	Certification:	2 Accident 3 Suicide 4 Homicide		not be 28e, P	lace of Inju- uilding, etc.	ry - At home (Specify)	, farm, str	M reet, factory		Yes 2		28f. Locatio City or	n (Street a Town, Sta	and Numl te)	ber or Run	al Route Num	ıber,
within 24 hours and the funeral sompletely filled	edical	29a. Certifier (Check only one)	2 Medical		ne basis of manner stat	examination ed.	and/or in	vestigation,	in my or	oinion, dea	ath occurr	ed at the tin	ne, date a	nd place,	and due t	o the cause(s	
To 1	Σ	29b. Signature and	title of certifie	ar /		2,5		290	License	number			29d. D	ate signe	ed (Month,	Day, Year)	
0		30. Name and addr	0 1	who completed of	cause of de	ath (Item 23	а) (Турв,	Print)	14	6/2	20		re	6.	10,	Day, Year); 200	10:
. Sta Registr		31. Date filed (Mon		2006	2 Registra	r's Signature	do	PFIC I	1450	xe-t	JVK.	vy (	-010 m	15,6		()	<u>U 4</u>

			For State Registrar		State	of Mary	land / De	epartme Certifica					giene Reg. No	HIII	06	
, . F	Physici	an	1. Decedent's Name (First, M	ddle, Last)								2. Date of De Month		, 2006	3. Tin	ne of Death
**	/Medic		James			Lee			cKinn		15 1	Februa				30 A M
	Examin	er	4a. Facility Name (If not institu			u <i>mber)</i>			ity, Town, or					County of De		
7753	£.		1804 Tufa Te 5. Social Security Number	6. Sex		7. Age (Ir	yrs. last birthe		Silver der 1 Year	If Under		8. Date of Bir	th	Montgo		ate or Foreign
	uneral rector		411 48 3809		M 2□F	68	. V-	Montl	ns Days	Hours	Min.	(Month, Da	iy, Year)			ate or Foreign
ס	, LL Alp		Usual Residence of Deceden									riai Cii	17.1	73/ IE	-,	
nylan	how		10a. State 10b. Cou	•		10	c. City, Town									le City Limits
ы Ма	Ba-f o	Director		gome	гу		Silver									Yes 2 No
vith th	or 2 be no		10e. Street and Number					10f.	Zip Code				10g. Cit	izen of What	Country?	
eath v	B 236	erai	1804 Tufa Te		12 Was Do	cedent Eve	rin II C	13 Was Da	209		ain? (San	noity Von or No		US.		2
<b>-0036</b> hours after death with the Maryland	irant.	Funerai	11. Marital Status  1 Never Married 2 1		Amand		1 11 0.3.	If Yes, s	pecify Cuba	in, Mexican	ı, Puerto	ecify Yes or No Rican, etc.)	,	Black, W		u,
U36	P. C.	by	3 Widowed 4 Divor		If Yes, C Year or	Dates: 55	-62	1 🗌 Yes	<b>¾</b> No	Specify:				Specify:	White	
2 P	acal B	Completed	15. Dece (Specify only hi	dent's Edu	cation		16a. D	ecedent's L	sual Occup	ation	t of worki	na	16b. K	ind of Busines	ss/Industry	
<b>21215-0036</b>	Med	npie	Elementary/Secondary (0-1	Ť		(1-4or 5+)		ite. DO NO	Tuse retired	dining mos	t di Wolki	ng	H	ealth 1	Plan	
Pd will	t, the	So				<u> </u>		Mar	ager					tal Wo	rkers	Union
Maryland d 2 should be file th and Mental Hy	even	Be	17. Father's Name (First, Mide									(First, Middle		Sum <b>ame</b> )		
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Man d 2 st	7 is r traur		19a. Informant's Name/Relati		248		1	- 5					50	(a) (a)	19 <u>60</u>	
e, - Heal	Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 ehow any injury or other traumatic event, the Mudical Examinar must be rutified at once.		Janet A. McKi 20a. Method of Disposition	•	•		180 20b. Place of D	<b>04 Tuf</b> Disposition (i	a Ter	Tace	Silv	er Spr	ing.	Mary I at ocation - City	or Town, Stat	0904
nor ages ant of			1 Burial 2 Cremati		emoval fron	n State	t Linco	crematory			/16/	2006	Bros	ntwood	Maru	l and
altimore, mit. Pages 1 ar partment of Hea	ortar injur	l i	21. Signature of Funeral S	+ +	90							es Rin	aldi	Funer	al Hon	e
n ga	eny Pny Sny		+aux	4	tim	Lou						e Ave S				
	*		23a Part1. Enter the disease shock, or heart failure.	, or compli	cations that	caused the	death. Do no	t enter the n	node of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approx	imate Between
Phy	sician		Immediate Cause (Final disease or condition	List Olliy Ol			oma Pad	. 1							Onset a	and Death
/Mc	edical		resulting in death)	-			ory Fa								2 D:	ays
Exa	miner		Sequentially list conditions.		Met	estat	ic Squa	amous	cell	Cance	r of	Lung			5 M	onths
D	=======================================	Examiner	if any, leading to immediate cause. Enter Underlying	1	Due to	o (or as a co	onsequence of	):							1	
ecute	and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	0	t.	n (or as a co	onsequence of	1.								
8760, cate be executed	physician and s the burial-transit	alE				0 (0, 00 0 0		,.								
587	phys s the	dical														
. Box 6	attending for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	2		utcome of p								23d. Date of c	felivery	
Box	d for	Physician/M	in the past 12 months?		4☐Pre	gnant at tim	Fetal death e of death	3 ☐ Ectopii 5 ☐ Other	pregnancy (specify)	1				Month	Day	Year
O E	by the a	hys	9 Unknown		9L] Unk	nown										
Records, P.O The law requires that the	gned be	by P	Part II. Other significant con	ditions cor	tributing to	death but n	ot resulting in t	he underlyin	g cause give	en in Part I.	*	23e. Did t	obacco u	use contribute	to the cause	of death?
ording a	been sig											TXCX	Yes 2	□No 3□	Probably 4	Unknown
BW F	as be 2 sh	Completed										24a. Was		24b. Were	autopsy findi o completion	ngs available
E E	ate h page	Ю										perfo	rmed? 2 <del>⊊</del> No	death		
/ita	nis certificate has I I director, page 2 s	Be (	25. Was case referred to med examiner?	-							of Death	(Check only	one)			
of Vita Physician:	this c	ု	1 ☐ Yes 2🛣 No	-			2 ER/Outp		DOA Oth	4 🗀 140		me 5 Resi			pecify)	
Division of Vital Records, for Attending Physician: The law requires taller death.	After th funeral	in o	27. Manner of Death 1 X Natural 5 ☐ Pe		28a. Dat (Mo	e of Injury onth, Day Ye	ar) 28b. Tir ∫ar) Inji	ury	28c. Injur			28d. Describe	how injui	ry occurred		
VISION Attending r death.	the f	cat	3 ☐ Suicide 6 ☐ Co	estigation uld not be	Offic Plan	oo of Isiust	At home form	M		Yes 2 🗌		28f. Location (	Straat an	nd Number or	Pural Pouta	Numbor
DIVI I or Ai	Director: in by the	Certification:	4 Homicide de	emined	buil	ding, etc. (S	- At home, farn Spec <i>ify)</i>	n, street, rac	tory, office			City or To			nurai noule	Number,
DIV To the Hospital or A within 24 hours after	To the Funeral Discompletely filled in		29a. Certifier Cert	fying Phys	sician: To t	he best of m	ıy knowledge, i	death occur	ed at the tin	ne, date an	id place.	and due to the	cause(s	and manner	as stated.	
• Ho:	Fut letely	edical	(Check only 2 Medi	cal Exami	ner: On the	basis of example of the contract of the contra	amination and/	or investigat	ion, in my o	pinion, dea	th occurr	ed at the time,	date and	d place, and d	ue to the cau	se(s)
To th within	To th comp	Me	29b. Signature and title of cer	tifier		7			29c. Licens	e number			29d. Da	te signed (Mo	nth, Day, Yei	ar)
			Lund	N	1/4	and d	1/		D359	996			Febr	uary 1	0. 200	)6
17	V		30. Name and address of per	son who co	omo d ca	use of death	h (Item 23a) (T	ype, Print)							, -00	-
			Linda Burre				Univers	ity B	lvd We	est S	uite	#400 W	heat	on, Ma	ryland	20902
1000	Sta	ite	31. Date filed (Month, Day, Y	ar) 1 200		Registrar's	Signature	beeck	•							

State of Maryland / Department of Health and Mental Hygiene [] For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vaar **Physician** 13:30 PM February 13, 2006 Marian E. Montgomery /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil Calvert Manor Healthcare Center Rising Sun If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 F Hours 85 July 6, 1920 Harrisville. 220-07-5989 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts 28e-f show traumatic avent, the Medical Examiner must be notified at 1 XYes 2 No Director Rising Sun Cecil 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 15 Walnut Street 21911 USA Itеms 23a death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Food Service Restaurant Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h Arvilla M. Terry Marion T. White ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 leany injury or other trains once. P.O. Box 611, Rising Sun, MD 21911 Martha Bussman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02-17-2006 Rising Sun, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Brookview Cemeteru 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licenses 111 S. Queen Street, Rising Sun, MD uchang 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Due to (or **Examiner** ongestive Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed use as the burial-transit nding physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à page 2 should be 2 De 100 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 22 No 24a. Was an autopsy performer certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 \ Homicide within 24 hours a To the Funeral D Hospita 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tula of certifier mpleted cause of death (Item 23a) (Type, Print 30. Name and address of perso istrar's Signatur State 2006 Registrar

			1 = For State Registrar		State c	of Maryla			of Health and of Death	d Mental H	ygiene Reg. No:	005	06173
	Physic		Decedent's Name (I     ALBER		")	NORI	WOOD			2. Date of D Month FEBR	Day	8 2006	3. Time of Death 5:17 P M
	/Medi Examir		4a. Facility Name (If no	ot institution, give		mber)			wn, or Location of De	eath	4c. Ca	ounty of Death	<u> </u>
	Funeral Director	Г	5. Social Security Num 254-38-927	6. Se		7. Age (In y 7 4	rs. last birthday) Yrs.	If Under 1	Year If Under 24 h	lin. (Month. L	lith Day, Year) I 4 193	9. Birthp Court GEOI	lace (State or Foreign ktry) RGIA
	yland now		Usual Residence of De 10a. State 1	ecedent 0b. County		10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	with the Maryland a or 28a-f ehow be notified at	ector	MD I	PRINCE G	EORGE'S	S I	LARGO	101 7 0					1 X Yes 2 □ No
	death with the Maryland ms 23a or 28a-f ehow Imust be notified at	al Dir	10204 PRI		E # 105	5		10f. Zip Co				n of What Cour S.A.	itry?
7 0/1/ 5-0036		by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4		12. Was Dec Armed Fo 1 12 Yes If Yes, Gi Year or D	orces? 2□NoAi ve	rforce	Vas Deceder Yes, specify I ☐ Yes 2	nt of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Nerto Rican, etc.)		Black, White,	an Indian, etc. ACK
-	y within 72 hours after jiene. r than "natural", or Ite Ite Medical Examina	Completed	15 (Specify Elementary/Seconda 11th		cation le completed) College (	1-4 <i>o</i> r 5+)	iire.	lent's Usual C kind of work o OO NOT use ECT MAI		working	16b. Kind	of Business/Ind	dustry
, ut 5/	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Italians	Be	17. Father's Name (Fir	rst, Middle, Last)					18. Mother's N	Name (First, Middle TAYLO		ımame)	
at	should and Men marke	2	19a. Informant's Name				19b. Mailir	g Address (S	Street and Number or	Rural Route Num	ber, City or T		
	1 and 2 Health a		RUBY NO	RWOOD/WI	FE	200	45 MA	GNA CA		NEWPORT 1	-	VIRGINIA tion - City or To	
$\frac{2}{8}/6$ (	Pages ment of ant: If It ury or o		1 🔀 Burial 2 🔲 0 4 🔲 Donation 5 [	Cremation 3 □F		State	cemetery, crer ARLINGTO	natory`or othe	r place)	8/2006		GTON, VI	
Balt	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny Injury or other trai		21. Signature of Funer	ral Service Licens	all	l			Address of Facility NDOVER RO.				HOME 20785
0	Physician /Medical Examiner		23a. Part1. Enter the of shock, or heart fall immediate Cause (Findisease or condition resulting in death)		a Meta	caused the depart line.	trè c		of dying, such as card	liac or respiratory Lung S			Approximate Interval Between Onset and Death  D munths
NORWOOD 68760,	ificate be executed g physician and as the burial-transit	edical Examiner	dequentially fist condi- if any, leading to imme- cause. Enter Underlyi, Cause (Disease or inju- that initiated events resulting in death) Last		s	(or as a cons							
FRT / P.O. Box 68	The law requires that the death certifical ste has been signed by the attending phypage 2 should be detached for use as the	by Physiclan/Medi	IF FEMALE: 23b. Was decedent printhe past 12 mo 1  Yes 2 N 9 Unknown	onths?		ointh 2∏Fe nantattimeo	etel death 3	Ect <i>o</i> pic pregr Other (speci			23d	I. Date of delive Month	ry Day Year
	quires that in signed b uld be deti	ed by PI	Part II. Other significa	int conditions co	ntributing to de	eath but not r	esulting in the ur	derlying caus	se given in Part I.				e cause of death?
I Reco	The law requirence that been some page 2 should	Completed		,							opsy ormed?	prior to con death?	osy findings available appletion of cause of
$A \mid \mathcal{B}$ Division of Vital Records,	Attending Physicien: Th r death. ector: Atter this certificete by the funeral director, pag	atlon; To Be	2 Accident	5 ☐ Pending investigation	28a. Date		ER/Outpatien 28b. Time of Injury		Othor	g Home 5 Res	sidence 🏍		Hospice
Divis	tal or Attend is efter death al Director: , ad in by the f	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e. Place buildi	of Injury - At ng, etc. (Spe	home, farm, stre city)	et, factory, of	ffice	28f. Location City or To	(Street and Nown, State)	lumber or Rural	Route Number,
	To the Hospital or / within 24 hours efter To the Funsral Dire completely filled in b	Medical (	one)		ner: On the ba	best of my k asis of exami ner stated.	nowledge, death ination and/or inv	occurred at t estigation, in	he time, date and pla my opinion, death oc	ice, and due to the curred at the time	cause(s) and , date and pla	d manner as sta ace, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title	o of certifier	DIN	4.	40		cense number		29d. Date s	igned (Month, E	Day, Year)
CA	-(11)		30. Name and address	of person who co	empletêd caus	se of death (It	tem 23a) (Type, I	Print)	, ,,	BALTU	MURE .	MD 71	225
	Sta Registr		31. Date filed (Month, L	Day, Year)			nature			10-111	- //		

Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 4 2006

			1 - For State Registrar  1. Decedent's Name (First, Middle, Las	State of Mary		rtificate				Reg Date of Death	g. No. (	006	06   76 3. Time of Death		
	Physici /Medio Examin	cal		equeline J.	Parnel	4b. City, 7	Fown, or Lanh	Location of [		Month Ebruary		Yeer 2006  ounty of Death	9:35AM George's		
(i)	Funeral Director	0	5. Social Security Number 6. Se	7. Age (In	yrs. last birthday, 2 Yrs.			If Under 24	Min.	Date of Birth (Month, Day, ) une 17,	1		place (State or Foreign ntry) Virginia		
	Ba-f show	ector	10a. State 10b. County  Maryland Prince (		c. City, Town or L	La	nham			10	- 0:4:		10d. Inside City Limits  Y☐ Yes 2 ☐ No		
	h with the	al Dire	10e. Street and Number 9902 Lanham—Seve	ern Road		10f. Zip	20 <b>7</b> 0	6		10	g. Citize	n of What Cou USA	ntry /		
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Markeal Examinat return 12br mailfied at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Deced If Yes, spec		spanic Origin n, Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No- can, etc.)		Race - Ameri Black, White, pecify: Whi	etc.		
21215-0	within 72 ho iene. then "natur the Maylcal	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th		(Give	edeni's Usua e kind of wor DO NOT us Binder	k done d e retired)	uring most o		10		of Business/fr	ŕ		
Maryland 2	ould be filed Mental Hygi warked other	To Be C	17. Father's Name (First, Middle, Last) John McCarthy					18. Mother's Vi	s Name (F irgin		aiden Si le Di	den Sumame)  Diamond  ty or Town, State, Zip Code)			
	nd 2 sh aith and 27 is m r traum		19a. Informant's Name/Relationship (7) Ralph J. Parnell	урө, Print) (Husband)		-			_	Route <i>Number,</i> Lanhan			o Code)		
iore,	ges 1 a it of Hea if item or othe		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □	Removal from State	Ob. Place of Disp	matory or ot	her place		Date			ition - City or T			
Baltimore,	permit. Pa Depertmen Important: any Injury once.		4 Donation 5 Other (Specify 21. Signature Principle Service Licen		MD Veter	2. Name and	d Addres	s of Facility		on/Hale l, Lanha	· Fu		ome		
	Physician /Medical Examiner	Iner	23a. Papt. Enter the disease, or composed to the control of the co	a. Due to (or as a co	nsequence of):	lier the mode Cirri Le, Franç		1		espiratory arres	st,		Approximate Interval Between Onset and Death		
68760,	Attending Physician: The law requires that the death certificate be executed rideath.  sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	n equence of):	emio									
P.O. Box (	at the death certific by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ 100 9 ☐ Unknown	23c. If yes, outcome of p 1	Fetal death 3	□Ectopic pre					23	d. Date of deliv Month	ery Day Year		
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontribuling to death but no	resulting in the	underlying ca	ause give	n in Part I.	_				he cause of death?		
al Records,	n: The law r licate has be r, page 2 sh	Completed									ed/ No	prior to co death?	opsy findings available impletion of cause of		
Ž	ysiclar s certil	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 ER/Outpatie	nl 3 DO	A Othe	-		Check only one 5 ☐ Residen		Other (Speci	fv)		
Division of Vital	ul or Attending Physiclen: The I after death. I Director: After this certificate ha d in by the funeral director, page	Certification: T	27. Manner of Death  1 Malural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye	28b. Time ( ar) Injury	of 2	8c. Injury Work		286	d. Describe how	v injury o	occurred	al Route Number,		
<u>&gt;</u>	5		4 Homicide determined  29a. Certifier 1 Certifying Ph	building, etc. (S ysician: To the best of m	<i>pecify)</i> y knowledge, dea	th occurred	at the tim	e, date and I	place, and	City or Town,	use(s) aı	nd manner as	stated.		
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of exa and manner stated.	mination and/or in	290	License		- 100	29	d. Date	signed (Month, $13$ , $)6$	Day, Year)		
e	(0)		30. Name and address of person who	completed cause of death			uck	Road,	Lanh	nam MD 2	2070	6			
7	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		e.		•							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 545 AM hilli 2006 -atherine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton P.G. Bradford Oaks Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 03/22/1931 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1□M 2□F North Carolina 74 Director 577-52-4848 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director MD PC Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20735 USA 7520 Surratts Road death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Diet Aide Private 12th Pages 1 and 2 should be filed inent of Health and Mental Hygisint: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mamie Dupree Charlie Wiggins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6307 Skyland Terr.; Suitland, Maryland Jean Smith - Daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Resurrection Cemetery 2/21/2006 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services P.O. Box 416; Suitland, Maryland 20752 23a. Page 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 3 Probably 4 Unknown 1 Tes 2 **N**No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Medical Certification; To 1 Tes this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide hin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 12070 Old Line Centre #207 Waldorf, Maryland 20602 Louis Kaufman, M.D. 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Maryland	-	rtment of H tificate of				ne 2006	06178
П			Decedent's Name (First, Middle, Last)		, -				Date of Death	Dav Year	3. Time of Death
	Physicia /Medic		James Robert Phal	.en				Fe	bruary	10,2006	4:45pm M
	Examin		4a. Facility Name (If not institution, give st	treet and number)	;	4b. City, Town, o	or Location of	of Death		4c. County of Deat	h
			Manor Care  5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast hirthday)	Rethes		24 Hrs. 8 [	Date of Birth	Montgome:	holace (State or Foreign
	Funeral Director			M 2□F 68		Months Days	Hours	Min. Ma	Month, Day, Y Irch 19	,1937 Am	untry) , IL
	D		Usuel Residence of Decedent	140.00							I dod I side Oil I i ii.
	arylar ahow	_	10a. State 10b. County		Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	tha M 28a-f	Director	DC None  10e. Street and Number	Was	hingto	10f. Zip Code			100	. Citizen of What Co	Δ.
	with Sa or	D.	4420 Fessenden St.	.N.W.		20016			100	United St	_
36	should be filed within 72 hours after death with the Maryland d Mental Hygene. marked other than "natural", or Itams 23a or 28a-f ahow marked other than "natural", or it er river to notified a matic event, the McAlcal Erwili er river to not be notified at	by Funerai		Was Decedent Ever in U.S Armed Forces?     ™Yes 2 No	1	Vas Decedent of I Yes, specify Cub			Yes or No- in, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
3	thour stural		15. Decedent's Educ	Year or Dates: 1962-	16a Deced	ent's Usual Occup	pation		16	ib. Kind of Business/	Industry
212	hin 72	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		kind of work done		t of working		Governmen	<b>-</b>
7	ed wit ygiene yer tha t, the	Completed		5+	Lobby	ist/Atto					-
ğ	a = 0 >	Be	17. Father's Name (First, Middle, Last) Richard E. Phalen						e Gerar	iden Sumame) d	
Maryland 21215-0036	should ba ind Mental s markad c umatic ev	2	19a. Informant's Name/Relationship (Type	pe. Print)	19b. Mailin	a Address (Street	and Numbe	er or Rural Ro	oute Number, C	City or Town, State, 2	Zip Code)
	and 2 s ealth an n 27 ls nar trau	Ì	Janice Bernhard Ph							ington DC	
re,	of Hea item otha	ŝ	20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of patory or other pla	ce)	Date	20	c. Location - City or	Town, State
<u>E</u>	Pages nant.of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ional	Cremato	ry ¦	2-14-0		alls Chur	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 its marked any injury or other traumatic e		21. Signature of Funeral Service License	on	5 ]	Name and Address	oss of Facilit	₩Joseph Ave,N.	Gawle W. Was	r's Sons, hington D	INC C 20016
Γ	*		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not ente	or the mode of dyi	ng, such as	cardiac or re	spiratory arres	t,	Approximate Interval Between
	Physician	8 1	Immediate Cause (Final disease or condition		Onset and Death						
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
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8760	cate be executad physician and the burial-transit	dical	d								
	ding p	a a	IF FEMALE:	3c. If yes, outcome of pregnar	nev					23d. Date of de	ivon
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rds, P	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ed by Physician/M	Part II. Other significent conditions con	tributing to death but not resu	Ilting in the ur	nderlying cause gi	ven in Part I	l. 			the cause of death?
Vital Records,	re law require has baen sig ge 2 should b	Completed							24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
		e Co	25. Was case referred to medical				ne Plane	o of Dooth (C	1 □ Yes 2X heck only опе)		2 No
₹	ysicia s cert directe	To B	examiner?	ospital: 1   Inpatient 2   1	ER/Outpatien	t 3 DOA Ct	her			ce 6 ☐Other (Spe	cify)
on of	ding Phys th. After this funeral di	tion: T	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Inju	4.6	28d.		injury occurred	
Division of	I or Atter after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	et, factory, office		28f.	Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific, completely illied in by the funeral director.	edical C		sicien: To the best of my knowner: On the basis of examinat and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier	c . l	1		se number			d. Date signed (Mont	
}	77		Kelern	G. N.la	lor	_ D231	.27		I	Feb 13,200	JO
			30. Name and address of person who co Kevin G. Nealon, M	mpleted cause of death (Item .D. 5530 Wisc	23a) (Type, Onsin	Print) Ave #925	Chev	y Chas	e,MD 20	0815	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 4 200	32 Registrar's Signal	ture	ule					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Feb. Waters Zabeth 2 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SALISBURY REHAB & NURSING CENTER 21804 WICOMICO SALISBURY, MD. If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 217-16-9568 Director Usual Residence of Decedent 10h County 10a. State 10c. City. Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Ma Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 201 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Important: if Item 27 is marked other then "natural", or Itame 23a eny injury or other traumatic event, the Medical Examiner miner 2009. Street A. 6 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ️ No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced BLACK 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BOARD OF Elementary/Secondary (0-12) College (1-4or 5+) Education 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mum waters HOWARD ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201-B retitt St. Snow Hill Md 21863
Date Date Oc. Location - City or Town, State Punnell Jr. (SON) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Snow Hill, Md 2-18-06 4 □ Donation 5 □ Other (Specify) Mt. Wesley Church Cem. 2) Name and Address of Facility
Bennie Smith Funeral Home
819 4th St. Pocomoke, Md 21. Sig Iture of Funeral Service Licensee Funeral Home LW 21851 nend 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** las major disease or condition resulting in death) a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1 Yes 2 N 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes, 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the Vasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

2 State

31. Date filed (Month, Day, Year)

WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

21804

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 13:03pm 2006 Myrtle Penhollow Feb. 10, /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Harford Upper Chesapeake Medical Center Belair If Under 24 Hrs. Hours Min. Birthplece (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days 1□M 2MF Months 215-42-9894 61 7/27/1944 Perryville, MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. Stete f Health end Mental Hygiena. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Elkton Cecil Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 16 Montgomery Lane 21921 Funerai filed within 72 hours aftar deeth 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐ No If Yes, Give Specify. White 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0020 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) Medical 12 Receptionist 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If flem 27 is marked ofth any liury or other traumatic event any injury or other traumatic event ance. 17. Father's Neme (First, Middle, Last) William Carsin Helen Todd 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Montgomery Lane Elkton, MD 21921 Allen L. Penhollow/ Husband 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/16/06 Havre de Grace, MD 4 ☐ Donation 5 ☐ Other (Specify) Rock Run Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Strano & Feeley Family Funeral Home leoun 635 Churchmans Rd. Newark, DE 19702 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical CARDÍAC ARREST Examiner Physician/Medical Examiner CARDIOVASCULAR DISEASE ARTERIOSCLEROTIC or Attending Physician: The law requiras that tha daath certificate be axecuted use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) the attending physician and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been signed by funeral diractor, page 2 should be detact HYPERTENSION à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No t□ Yas 2XNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 XYes 2 No 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? s aftar death.

i Director: After the operation of the function of the functions of the fun 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital of within 24 hours a To the Funersi D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier (Check only one) end manner stated. 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature end title of certifier Mellestern D45344 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 622 S. UNION AVE, HAYRE DE GRACE, MD 21078 SURESH DHANJAN

DHMH 16 Rev 6/95

Registrar

32. Registrer's Signeture

Bours

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2006

		1 - For State Registrar	State of	Marylan		artment of rtificate of		d Mental H	ygiene Reg No.	06 (	06181
Physicia		1. Decedent's Name (First, Middle, Gilbert W	illard	Per	ry			2. Date of D Month Feb		2006	3. Time of Death 9:15 p.M
/Medic Examin		4a. Facility Name (If not institution,					or Location of De		4c. Coi	unty of Death	
Funeral Director		Sunbridge Ca 5. Social Security Number 215-16-0087		lab 7. Age (In yrs. i 83	last birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, L		9. Birth	place (State or Foreign ntoy) Land
e Maryland Be-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Ceci	1		y.Town or Lo						10d. Inside City Limits 1 □ Yes 2 ☑ No
with the	ai Dire	10e. Street and Number 1203 Telegra	ph Rd.			10f. Zip Code 21912	2		10g. Citizen	of What Coul	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deparmic. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. I morrise and Mental Hygiene. The marked other than "natural", or items 21 a marked other than "natural", or items any injury or other treumatic event, the Madical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 Marrie  3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 MYes 2 If Yes, Give Year or Dat	ces? 2 □ No 1 Q /L	.   '	Was Decedent of f Yes, specify Cult 1 ☐ Yes 2 🗷 No	oan, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		Race - Americ Black, White, ecity: Whi	etc.
within 72 houndless in a Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4	4or 5+)	(Give lite.	dent's Usual Occu kind of work done DO NOT use retin her (Cu	during most of (ad)			ation	•
uld be filed v Aental Hygie rked other tic event, the	To Be Co	17. Father's Name (First, Middle, La Charles			reac	ner (oa		Name (First, Middl			
nd 2 shoulth and N 27 Is ma		19a. Informant's Name/Relationshi	rry-wife	)				Rural Route Num	-		
Pages 1 and nent of Health out: If Item 27 arry or other tr	- 10	20a. Method of Disposition  1  Burial 22 Cremation 3  4  Donation 5  Other (Spe		late	_	sition (Name of matory or other pla Cremat	. 1 /	Date -16-06	20c. Locati	on - City or To	own, State
permit. Departn Importe any inju		21. Signature of Funeral Service L	Sitchia	Lme				DANIELS			ЙС
Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a Chr	ch line.	struct			ry Dise			Approximate Interval Between Onset and Death  Whan mun
cate be executed  physician and the burial-transit	ai Examiner	Sequentially list conditions, tay, hading to in incidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	r as a consequence as a consequence							
The Hospitel or Attending Physicien: The law requires that the death certificate his 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physholetely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown		th 2 ☐ Fetal ntat time of de	Ideath 3	Ectopic pregnand	гу		23d.	Date of delive Month	ery Day Year
uires that in signed by	by	Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the u	nderlying cause g	ven in Part I.		I tobacco use o		he cause of death?
The law requir	Completed							24a. Wa aut per 1 🗆 Yes	opsy formed?	4b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ In	patient 2	ER/Outpatien	it 3□ DOA		Death (Check only		Other (Specif	(v)
ending Ph eath. or: After th	Certification: T	27. Manner of Death  1 XNatural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion	Injury , Day Year)	28b. Time of Injury	We			how injury oc		
vitel or Attendi		4 Homicide determin	ed 28e. Place of building	g, etc. (Specif)	y) 	eet, factory, office		City or To	own, State)		al Route Number,
To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	edicai	29a. Certifier 1	Physician: To the base caminer: On the base and manne	sis of examina	wledge, death tion and/or in	n occurred at the twe stigation, in my	ime, date and pla opinion, death o	ace, and due to the courred at the time	e cause(s) and e, date and pla	manner as s ce, and due to	tated. o the cause(s)
To t To t	Σ	29b. Signature and title of certifier	ler S M	D		-	se number 23322			gned (Month. 15,	
5+IVA		30. Name and address of person w	no completed cause	of death (Item		Print)					
Sta Registr		31. Date filed (Month, Day, Year) FEB 1 5	00.04	hdev, gistrar's Signa			th St.	Elkton	, MD		

		4	For State Registrar	State of Maryland	-	ertment of H			giene 006	06182
4			Decedent's Name (First, Middle, Last)					2. Date of De	aath	3. Time of Death
	Physicia /Medic		AGNES	E. ROBEI	RTSON			FEBRUAI		6 11:10 A <sup>M</sup>
	Examin	26. 15	4a. Facility Name (If not institution, give stre PRINCE GEORGE S			4b. City, Town, or	r Location of Dea	ath	4c. County of Dea	
* No.	Francis		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 Hr			
	<ul> <li>Funeral Director</li> </ul>			<sup>2</sup> ⊠F 83	Yrs.	Months Days	Hours Mir	OCTOBE	R 2 1922 WE	rthplace (State or Foreign ountry) ST VIRGINIA
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	sho	5								1 X Yes 2 No
	28a-1	Director	MD PRINCE GEO	JRGE S G	LENAR	10f. Zip Code			10g. Citizen of What C	ountry?
	h with		7902 CAWKER AVEN	JE		2070	06		U.S.A.	
	ema 2	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S Armed Forces?	. 13. \	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No orto Rican, etc.)	14. Race - Am Black, Whi	
20	be filed within 72 hours after death with the Maryland all Hyglene.  do ther than "natural", or itema 23a or 28a-f show dother than "natural", or itema 23a or 28a-f show avant, the Madical Examiner must be confiled at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2🛣 No	Specify:		Specify:	BLACK
9500-61212	2 hour		15. Decedent's Educat	ion	16a. Deced	dent's Usual Occup	ation		16b. Kind of Business	s/Industry
<u>င</u> ြ	within 72 ene. then "na!	Completed	(Specify only highest grade c Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work done of NOT use retired	during most of w ii)	orking		
	e filed within al Hygiene. I other than "	Con		4 yrs	ACQUI	STION ASS		(Fig. 84)-44	GOVERNMEN	IT
and	ntal H ed oth	Be	17. Father's Name (First, Middle, Last)  LAWRENCE G. BANKS				LURLEY	,	o, Maiden Sumame) ON	
<b>S</b>	2 should be fill and Mental H le marked otl aumatic avan	2	19a. Informant's Name/Relationship (Type)	oer, City or Town, State,	Zip Code)					
2	nd 2 salth ar 27 le r trau		JUANITA SCOTT/SIST	-					MARYLAND	20706
ē,	es 1 and 2 should to by Health and Ment fitem 27 le marked rother traumatica		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Rem	20b. Pla	ace of Dispo	sition (Name of matory or other place	Ce)	Date	20c. Location - City o	r Town, State
Ĕ	Pages ment of ant: If it ury or o		4 ☐ Donation 5 ☐ Other (Specify)	HARN		EMETERY		23/2006	LANDOVER, MA	
Baltimore,	permit. Pages. Department of h Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee	hall		2. Name and Addre			NKINS FUNER VER, MARYLA	
28/g	* 4		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death.	Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory a	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	METASTATIC						Onset and Death
3.	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
Ö,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
9780	physic physic s the b	dical	d							
Box	eath certific attending p	n/Me	IF FEMALE: 23c. Was decedent pregnant 23c.	. If yes, outcome of pregnan		De			23d. Date of de	alivery
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dead of 9 ☐ Unknown		Ectopic pregnancy Other (specify)	· · · · · · · · · · · · · · · · · · ·		Month	Day Year
о. О	d by t	Phy	9 ☐ Unknown  Part II. Other significant conditions control	buting to death but not resul	Iting in the u	nderlying cause div	en in Part I	23e. Did	tobacco use contribute	to the cause of death?
Records,	n requires that the de been signed by the should be detached		•	·	•	, 3		10	Yes 2XNo 3□F	robably 4 Unknown
S	s beer s beer	Completed						24a. Wa	s an 24b. Were a	autopsy findings available ocompletion of cause of
Re	hysician: The law his certificete has t I director, page 2 s	mo						auto perf	ormed? death?	s 2X No
Vital	striffice octor, p	Bec	25. Was case referred to medical examiner?					eath (Check only		
	Physic this ce	မှ	1 ☐ Yes 2 🛣 No		R/Outpatier				idence 6 Other (Sp	ecify)
Division of	ding F h. After funera	tlon;	27. Manner of Death  1 ∑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk? Yes 2 □ No	26d. Describe	mow injury occurred	
/ISI	Attendi ar death. rector: A by the fu	fica	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor	me, farm, str				(Street and Number or I	Rural Route Number,
á	s after al Dire ed in by	Certification;	4   Homicide	building, etc. (Specify,	) 			City of 10	JWII, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	tien: To the best of my know r: On the basis of examinati and manner stated.	vledge, deat on and/or in	h occurred at the ti vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) and manner a , date and place, and di	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1.		29c. Licens	se number		29d. Date signed (Mo.	
	1		N/ Vh	rtun		D4	6591		2-14	-06
1	(7)		30. Name and address of person who com NDUBULSI ACHUFUSI				CI ENVODI	EN MADVI	AND 20706	
13	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure -	and a second	STEMARDI	111 9 THAIR I LIZ	.IIID 20700	
. '	Regist	rar	FEB 1 5 2006	Block &	1000	E)				

			For Stete Registrer	State of Ma	ryland / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>			ene 9. No. 0 0	6	06183	
			Decedent's Name (First, Middle, Last)					2. Date of Death Month		Year	3. Time of Death	
	Physici /Medic		Shirley Virginia	Ranoull				Februar		2006	1724 <sup>M</sup>	
	Examin		4a. Facility Name (If not institution, give s Carroll Hospital C				Location of Death		4c. County o	of Death rrol	1	
	Funeral Director		5. Social Security Number 6. Sex 218–32–8480	7. Age	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul 13,	1936	9. Birthpl Count Mary.		
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ncation				10	0d. Inside City Limits	
	Aaryla F aho	٥	Maryland Carroll		roo. Ony, rown or E	V	Westminst	er		"	1 ☐ Yes 2 ☑ No	
	128a-	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	/hat Count	try?	
	th with	ai D	815 Fairfield Ave	nue			21157		USA	4		
	-ma	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecity Yes or No- Rican, etc.)		- America		
36	urs afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 [∑]N If Yes, Give Year or Dates:	lo	1□Yes 2√ No	Specify:		Specify:	W	hite	
200	72 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation	ina 1	6b. Kind of Bu	sin <i>e</i> ss/Ind	ustry	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28s-f show the Moulcal Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired LPN	)	9	Nurs	ing		
	should be filed within marked other than marked other than imatic evant, the W	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name					
/lar	ould be Mental Parked c	To E	Vernon Emory Rin	eman			Mary C	atherine	Seller	S		
Maryland			19a. Informant's Name/Relationship (Ty) Richard E. Ranoul			ng Address (Street a 5 Fairfie						
Baltimore,	Pages 1 and 2 nent of Health ant: If Itam 27 I ury or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		osition (Name of matory or other plac neran Cem	e) 00/4	4/2006	Manche	-		
Balti	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service License	MO1	191 2	2. Name and Addres	ss of Facility M S Street,	yers-Dur Westmin				
		7	23a. Pan 1. Enter the disease, or complishock, or heart failure. List only on	st,		Approximate Interval Between						
	Physician		Immediate Cause (Final disease or condition	Ce	11. Ditie					C	Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	1					Va	
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence of):	PS: My					1eas	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Reci	piratory	Acids	05/S			1	asc	
oʻ	e exec ien ar urial-ti	EX	resulting in death) Last	Due to (or as	consequence of)	1.	1.		•		1	
68760,	icate be executed physicien and s the burial-transit	dicai		. Rest	rictive	ang	aiseas.	2		7	eass	
. Box	The law requires that the daath certifi ate has been signed by tha ettending page 2 should be deteched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 floriths? 1 Yes 2 Her 9 Unknown	3c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	e of delive	ry Day Year	
P.0	that the	F.	Part II. Other significant conditions con	tributing to death bu	at not resulting in the a	inderlying cause give	en in Part I.	23e. Did tob	acco use contri	ibute to the	e cause of death?	
rds,	quires n sign uld be							1 □ Ye	s 21346	3 🗆 Proba	ably 4 \( Unknown	
Records,	law requir as been si 2 should	Completed						24a. Was an	/ p	rior to con	osy findings available inpletion of cause of	
a R								perform 1 Yes 2	19d2- d 1940- 1	eath? ☐ Yes	2□ No	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	• • • • • • • • • • • • • • • • • • •	Othe	26. Place of Death				,	
o	£ = <u>a</u>	n: To	27. Manner of Death	28a. Date of Injur (Month, Day		nt 3LI DOA	4   Nursing Ho	me 5 Resider 28d. Describe hor			1	
ion	Attanding r death. actor; After by the fune	atio	Natural 5 Pending investigation	(Month, Day	Year) Injury		Yes 2□No					
Division	ol or Attu after de I Diracto d in by ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	iry - At home, farm, st . <i>(Specify)</i>	reet, factory, office		28f. Location (Str City or Town,		er or Rural	Route Number,	
	To the Hospitel or Attandi within 24 hours after death. To tha Funeral Diractor; A completely filled in by the fo	Medical (	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examir	icien: To the best of ier: On the basis of and manner sta	of my knowledge, dea examination and/or in ted.	th occurred at the time evestigation, in my of	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and mar ite and place, a	nner as stand due to	ated. the cause(s)	
	To the Comp	Σ	29b. Signature and title of contitler	, /		29c. License	e number	29	d. Date signed	(Month, L	Эау, Year)	
	105		· wwy	U NI	<u> </u>	Do	05813	2	2/1	3/0	6.	
	5		Willow Ku.	295	Stone	Are St	- 307	Western	nster	MO	21157	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature  FEB 1 3 2006									

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** FEBRUARY 16 PAUL GARRISON RENSHAW, SR. 2006 6:00PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 29379 HAWKES HILL ROAD EASTON TALBOT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) NOV. 14 1943 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Months Hours **X** M 2 □ F MARYLAND Yrs. 62 218-40-6103 Director Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23s or 28s-1 show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral', or itams 23a or 28a-f show Examiner must be notified at 1 XYes 2 No EASTON TALBOT MD Directo 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 USA 29379 HAWKES HILL ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No !f Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced WHITE ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) GROCERY PRODUCE MANAGER 12 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be E. RICHARD RENSHAW, SR. RUTH CALLAHAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29379 HAWKES HILL ROAD, EASTON, MD 21601 DEBORAH A. RENSHAW/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 2/22/2006 EASTON, MARYLAND ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERLERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cholongio (
Due to (or as a consequence of): caranom Zyears **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 2 After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manger of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 06 who completed cause of death (Item 23a) (Type, Print) 15cc 29466 PINTAIL DRIVE, EASTON, MD 21601 DAVID SMITH M.D., 32. Registra's Sign State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelith and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show amy injury or other traumatic event, the Medical Exa. siner man be notified at once. Baltimore, Maryland 21215-0036

**Funera** Directo

Physician /Medica Examine

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Walter Momas  4a. Facility Name (If not institution, give street and number)	Rad Cliffe  4b. City, Town,	or Location of Death	16 2006 0316 .  4c. County of Death
ner	University of maryland Medica	alcenter Balt	more	NIA
	212-13-1556 <b>X</b> □M 2□F	19 Yrs. Isst birthday) If Under 1 Year Months Days		9. Birthplace (State or MARYLAND)
]	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location		10d. fnside City
Į.	MD TALBOT	TRAPPE		1 □ Yes 2
Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	4411 WINDY HILL ROAD		21673	USA
Funerai	11. Marital Status 12. Was Decedent E	ver in U.S. 13. Was Decedent of	Hispanic Origin? (Specify Yes or Noan, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
by Fu	Armed Forces?  1 Never Married 2 Married 1 Yes 2 N  3 Widowed 4 Divorced Year or Dates:	0 1 ☐ Yes 2 🔼 No		Specify: WHITE
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	16b. Kind of Business/Industry
Comp	Elementary/Secondary (0-12) College (1-4or 5-	STUDENT		EDUCATION
Be	17. Father's Name (First, Middle, Last)  JEFFERY L. RADCLIFFE		18. Mother's Name (First, Middle SANDRA A.	
2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stree		ber, City or Town, State, Zip Code)
	JEFFERY L. RADCLIFFE/FATHER		HILL ROAD, TRAF	
	20a. Method of Disposition	20b. Place of Disposition (Name of	Date	20c. Location - City or Town, State
	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	LANDING NECK CEM		TRAPPE, MARYLAND
	21. Signature of Funeral Service Licensee	FELLOWS Add	HELPENBEIN & NEW	MAM FUNERAL HOME PA
	Joseph M. Ostrowski C.F. S	200 S. HA	RRISON ST EASTON	
i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):  Motor Veh a consequence of):	U	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of 1   Live birth 24   Pregnant at 9   Unknown	2 ☐ Fetel death 3 ☐ Ectopic pregnand	CERTIFICATION TO THE	27d. Date of delivery  Month Day Yes
by	Part II. Other significant conditions contributing to death but	it not resulting in the underlying cause gi		d tobacco use contribute to the cause of dea
Completed			24a. We aut per 1 □ Yes	topsy prior to completion of caudentificated?
Be	25. Was case referred to medical examiner?	0	26. Place of Death   Check only	one)
. To	Yes 2 □ No Hospital: Inpatier  27. Manner of Death 28a. Date of Injur	nt 2 Envoupationt 3 DOA		sidence 6 Other (Specify) e how injury occurred
ertification;	1 Natural 5 Pending (Month, Day 2 Accident investigation 2 11 O	injury Wo	Yes No Moror	VENICIA, Collison (Street and Number or Rural Route Number own, State)
O	29a. Certifier  (Check only one)  1D. Certifying Physician: To the best of cone one)  1D. Certifying Physician: To the best of cone one one one one one one one one one	examination and/or investigation, in my		ne cause(s) and manner w stated. e, date and place, and due to the cause(s)
dic	29b. Signature and title of certifier		nse number	29d. Date signed (Month, Day, Year)
Medicai	) Justiff h	P	19812	02/16/2006
Medic	30. Name and address of person who completed cause of de		uland Mode	02/16/2006 cal Center

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		•	1 - State Registrar	State of Maryla		artment of F tificate of			giene Rag. No.	306	06186
	Physici	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month Februar		), 2ŎÖ6	3. Time of Death 12:35 P M
	/Medic	cal	Ralph M. Race  4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Deat			County of Death	12:3) P M
	Exami	iei	Memorial Hospita			Cumbe:			A1	legany	
Ī	Funeral Director		5. Social Security Number 6. Sex 213-01-5920	M 2□F 7. Age (In yrs	. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1 3 1		place (State or Foreign htry) ryland
	and **		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation					0d. Inside City Limits
	Maryl	tor	MD Allegany	y Fro	ostbur	g					1⊈Yes 2□No
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	I Director	10e. Street and Number 40 Bealls Lane			10f. Zip Code 21532			10g. Citize US	en of What Cour A	ntry?
	s within 72 hours after death with the Marylan piece. Then "natural", or Iteme 23a or 28a-f show the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub I ☐ Yes 2☐MNo	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
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7	filed within Hygiene. ther then "		1 2 17. Father's Name (First, Middle, Last)	3	Exe	cutive	18 Mother's Na	me (First, Middle,		king	
yland	e d ia b	To Be	Milton W. Race	e			_	Gunnett		ace	
Mary	s 1 and 2 should f Health and Men Item 27 is marke other treumatic	-	19a. Informant's Name/Relationship (Type Fred S. Taylor	Nephew		-		ural Route Numbe	-		
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Ē	Pages nent of ant: If I		1 Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State F1	rostbu	_	Park Fe	b 25 06			
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		21. Sign, ture of Funeral Service License			vice, PA					
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<u>)</u> . I	Physician		Immediate Cause (Finat disease or condition	Hweteple I				by Hypo		mia	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse				7 71			
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x		Completed	Disease							24b. Were auto prior to co death? 1 12 Yes	psy findings available mpletion of cause of
Z I	certific	Be	25. Was case referred to medical examiner?  1 X Yes 2 No	ospital:	XER/Outpatier		000	eath (Check only o		CO. 10. 10. 1	
ō	ding Phys h. After this funeral di	n: To	27. Manner of Death	1 ☐ Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	28b. Time of	" 30 DOV	4 Lituising	Home 5 Resid	now injury	occurred 511	west in a
Division of Vital R	tending l death. tor: After the funer	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	2/19/06	9:20	A-M 10	Yes 2 No	MVA and	CULVE	posed t inventa I Number or Rure	Temperative
<u> </u>	To the Hospital or Attending Physician: within 24 hours elfer death. To the Funerel Director: Affer this certific completely filled in by the funeral director.	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, str cify) ad Wa Y	eet, factory, office		City or Tow	vn, State)	Finzei	Koad
	Hospit 24 hour Funere tely fille	Medical		sician: To the best of my kiner: On the basis of examin							
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
)			· Caroet	allann	y	0.0	C.M.E.	I	Febru	ary 21,	2006
	20		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print) 1 Penn S	treet, Ba	altimore,	, Mar	yland 2	1201
8	Sta	ate	31. Date filed (Month, Day, Year) MAR () 1 20	32 Registrar's Sign		www.	a .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11em 7 per fh 9833 3-1-06 vt State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Charles Edgar Spiker 02 23 2006 8:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg, MD
If Under 1 Year | If Under 24 Hrs. St. Vincent DePaul Nursing Center Allegany 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ÑOM 2□F Months Days Hours Yrs. Director 214 16 2748 85 MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at or 28a-f shov 1X Yes 2 □ No Directo MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10805 WELSH HILL 21532 U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 250 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2💢 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within ; th and Mental Hygiane. 7 Is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) LABORER TIRE BUILDING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM HENRY SPIKER CHARLOTTE POLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 ls BONNIE JACKSON / DAUGHTER 30 McCulloh Street, Frostburg, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o ▼☐ Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) 2/25/06 LaVALE, MD RESTLAWN MEMORIAL GARDENS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET moosy7 SOWERS FUNERAL HOME, P.A. owers FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final obstructive Lime disease Physician stage chromic End disease or condition resulting in death) 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1 ☐ Yes 2**8** No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 3 DOA iuneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending daath, investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number worsothelle MD Do055325 Feb 23, 2006

Registrar

State

Frostburg

Mb2/532

48 Tarn

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

WONSOCK SHIN MD

31. Date filed (Month, Day, Year)

		•	For State Registrar	State of	Marylan		artment of H tificate of L		nd Mental H	Reg. No.	105	06188
4	Physicia	an	Decedent's Name (First, Middle     DIDY	e, Last)	COLOM	OM			2. Date of D Month	Day	Year	3. Time of Death
	/Medic	al	RUBY  4a. Facility Name (If not institution	give street and numb	SOLOM	.ON	4b. City, Town, or	Location of	FEBRUA f Death	1	2006 ounty of Death	7:10 A M
	Examin	er	SOUTHERN MARYLA	•			CLINTON			PR	INCE GE	ORGE
War	Funeral Director		5. Social Security Number 254-44-5320	6. Sex 1 ☐ M 2 🔏 F	Age (In yrs. i	(ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of 8 (Month, 1 1 - 24	irth Day, Year) -1915	9. Births Cour GEOR	place (State or Foreign htry) LGIA
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation				1	10d. Inside City Limits
	Mary Ff sho	tor	MD PRINCE	GEORGE	TEM	PLE HI	LLS					1X Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code			-	en of What Cour	ntry?
	s 23s	rail	5308 CHESTERFIE	LD DRIVE	ont Ever in III	C 12.1	20748	ispanic Orio	gin? (Specify Yes or I	L	U.S.A.	can Indian.
36	72 hours after death with the Maryland natural; or ttems 23s or 28s-f show alcal Examinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marr  3 ☒ Widowed 4 □ Divorced	Armed Forc	es? No		If Yes, specify Cuba	Specify:	, Puerto Rican, etc.)		Black, White,	
50	72 hours "natural", alical Exp			t's Education st grade completed)		16a. Dece	dent's Usual Occupa	ation during most	of working	16b. Kind	d of Business/In	dustry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12) 3rd	College (1-4	lor 5+)	life.	DO NOT use retired USEWIFE	()		PRI	VATE	
and ;	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, UNKNOWN	Last)					r's Name (First, Midd E HANDFORD	le, Maiden S	umame)	
Maryland	12 sh h and 7 is m traum	Jo	19a. Informant's Name/Relations ANNIE MACK/DAU						or or Rural Route Num			
Baltimore, I	Pages 1 and 3 nent of Health int: If item 27 iry or other tra		20a. Method of Disposition  1 XBurial 2 Cremation 4 Donation 5 Other (S		ate	emetery, cre	osition (Name of matory or other place CEMETER)		Date 02-18-2006		ation - City or To	
Baltir	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service		0	25	2. Name and Addres	ss of Facility	JE JENKI LANDOVER	NS FUN	ERAL HO	
1			23a. Part1. Enter the disease, shock, or heart failure. List	complications that car	used the deat ch line.	h. Do not en	ter the mode of dyin	g, such as	cardiac or respiratory	arrest,		Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	a	Ke	06	farher	_				Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a Snseq	uende of).	1000					
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8760,	be exe		resulting in death) Last	Due to (o	r as a conse	uence of):						
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4	quires that I n signed by Jid be deta	by	Part II. Other significant conditi	ons contributing to dea	ath but not res	sulting in the u	ınderiying cause giv	en in Part f.		d tobacco us	_	the cause of death?
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of Vital	Physician: The this certificate ral director, pages	Be	25. Was case referred to medica examiner?	Hospital:	_		oth Oth	or	of Death (Check onl			
	Phys r this ral dir	5	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a Date of	Injury	ER/Outpatie	III JUDOA	4 🗆 Nu	rsing Home 5 Re 28d. Describ			fy)
ion	Attending Firdeath.  octor: After by the funer	atlor	1 Natural 5 ☐ Pendii 2 ☐ Accident invest	ng (Month igation	, Day Year)	Injury		rk? Yes 2 □	No			
Division	al or Atts after des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   206. Place	of Injury - At h g, etc. (Speci	ome, farm, st	reet, factory, office		28f. Location City or	(Street and Town, State)	Number or Rui	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (		ng Physicien: To the base and manner	sis of examina							
	To the To the comp	Me	29b. Signature and title of certifie	MD .			29c. Licens	9 9 7	-7	29d. Date	signed (Month)	, Day, Year)
R	(b)		30. Name and address of person	who completed cause		_	, Print)	95H.	De 20	002	1, ~	
	St Regist	ate rar	31. Date filed (Month, Day, Year		gistrar's Signi		E)					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day Ves **Physician** February 9, 2006 Viola Mae Spears 9:50 A.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Prince George's

9. Birthplace (State or Foreign
Country)
Lott, Texas Center Cheverly 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Y 3/23/24 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 1 F Director 459-28-4045 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits M☐ Yes 2 ☐ No Md. P.G. Director Capitol Heights 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1429 Eastern Ave. U.S.A.

14. Race - American Indian,
Black, White, etc. 20743 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore. Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black \$ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary 10th Court of Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. O'Neal Lillie R. Paul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gwendolyn E. Musgrove/Daughter 1429 Eastern Ave., Capitol Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Brandywine, Md. 4 ☐ Donation 5 ☐ Other (Specify) Apostolic Faith Church Cem. 2/15/06 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21 Signature of Funeral Service Licenses 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Seizure Disorder Examiner Due to (or as a consequence of): Multivessel Cerebral Infarction Physician/Medical Examine attending physician end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its total as to the cause of the Essential Hypertension Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) Hypothyroidism Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 25 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? has le 2 s certificate has 1\_Yes & No 1 ☐ Yes 2 ☐ No or Attending Physician: : After this certification : After this certification : 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ★Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: 1 Natural Iniun 5 Pending 1 🗌 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: Af death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Gertifier Medical (Check only one) and manner stated

Registrar

31. Date filed (Month, Day, Year) State FEB 1 6 2006

30. Name

29b. Signature and title of certific

George Bone, M.D. 1100 Mercantile Lane,

Largo, Maryland 20774

29c. License number D31069

29d. Date signed (Month, Day, Year)

2/10/06

dress of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryla	nd / Depa		Health and M	Mental Hygi Re 2. Date of Death	ene g/N <sub>o</sub> 0 0 6	0 5 1 9 0 3. Time of Death
Ex	nysicia Medic xamin	al er		treet and number) ing Home	Sutherl	4b. City, Town,	or Location of Death Wie	Month  ()  8. Date of Birth	0. 8:4	George's
Dire	neral ector		156-50-6174  Usual Residence of Decedent	M 2XIF 93	Yrs.	Months Days		Month, Day, Dec 18,	1912 Jama	nplace (State or Foreign untry)
the Marylar	notified at	Director	10a. State 10b. County  Maryland Prince C  10e. Street and Number		City, Town or Lo		owie	10	g. Citizen of What Co	10d. Inside City Limits 1 XYes 2 No untry?
h with	atke	io le	16009 Pond Meadow	<i>I</i> Lane		20	716		USA	
within 72 hours after death with the Maryland with one "artural" or lieuns 23s or 28s-1 show than "natural" or lieuns 23s or 28s-1 show	imporent. It remains the marked other than it is the first that the notified at 2008.	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 XVidowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ZÃNo If Yes, Give Year or Dates:		1□Yes X∷No				s, etc. Black
thin 72 h	Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life.		a during most of work ad)	ring 1	6b. Kind of Business/l	•
filed wi	E E		8th			Homema		e (First, Middle, M	Private	2
Id be fill bental H	ic ever	To Be	17. Father's Name (First, Middle, Last) Simeon McCrae					ella Elli	•	
E, INGITYIGITU Z I Z I 3-0030  1 and 2 should be filed within 72 hours at Health and Mental Hygiene. Health and Antarthan "natural" or	er treumal		19a. Informant's Name/Relationship (Type Beverly Nettleford						City or Town, State, 2 MD 20716	ip Code)
Dallimore, permit. Pages 1 ar Department of Hea	ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation ③ ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		cemetery, cre onmouth		1 Pk 2/17,	/2006 I	oc. Location - City or inton Fall	ls, NJ
permit. Page Department of	any inju		21. Signature of Funeral Service License	ive, Land	lover, MD :	rices, P.A. 20735				
Exam	dical niner	Examiner	23a. Part1. Enter the disease, or on the shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events can be a caused to the cause of the cause o	Due to (or as a cons	RES equence of): LAR					Approximate Interval Between Onset and Death
VISIOIT OF VITAI NECOLUS, F.C. BOX 69/760, Attending Physicien: The law requires that the death certificate be executed in death. Ander this certificate has been sinned by the allending physician and	ed by lite attending physician and detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a cons	gnancy stal death 3[	□Ectopic pregnan	су		23d. Date of deli Month	very Day Year
hat the de	tached	hysi	1 □ Yes 2 ⊅ No 9 □ Unknown	9□ Unknown						
equires the	should be deta	by	Part II. Other significant conditions con	tributing to death but not r	_		iven in Part I.	23e. Did tob	acco use contribute to s 2 ⊠No 3 □ Pro	the cause of death?
VICION: The law requires t	# CV	Completed						24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
VICAL F Sicien: Th	rector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	☐ ER/Outpatie	- 25 004 0		th (Check only one	nce 6 Other (Spec	
I or Attending Phys after death.	fune	H	27. Manner of D-ath  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. lnj	7	28d. Describe hor		ny)
DIVISION SPITAL OF Attended hours after death	ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
24 H	etely fill	edicai		icien: To the best of my ker: On the basis of exami and manner stated.						
To the within	сощо	Me	29b. Signature and title of certifier	6-	Λ	29c. Licer	ise number		d. Date signed (Month	
TI	)		· wyny!	molected assess of the second	U	Print)	45217		2/13/c	6
- U	!		30. Name and address of person who co	/	E (215	CA1EC	ADEROW.	MD 2	c740	
* *} <b>R</b>	Sta legistr		31. Date filed (Month, Day, Year)  FFR 1 6 2006	82. Registrar's Sig	nature	Bi !				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month February 11 11:00 p<sup>M</sup> David Michael Smith 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 15 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 ☐ F Yrs. 80 Director <u>218-14-9760</u> MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23a or 28a-f show the Maxical Examiner must be notified at MD Carroll Westminster Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 385 Tanyerhyde Drive 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ∑Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 200 No White Specify: þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Company 4 General Manager marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental sout: If item 27 ie marked o Albert L. Smith, Sr Elizabeth Sudina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 385 Tanyerhyde Drv Westminster, MD 21157 Lynn Gondeck/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ortent: If i 1 D'Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or 2/15/2006 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Pk Sykesville, MD Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhagic **Physician** CVA 24 hrs disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy j in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ector, page 2 should be 12Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No this certificate 20 No 1 Yes Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Nnpatient 2 ☐ EP/Outpatient 3 ☐ DOA funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident To the Hospitel or Attence within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) H53939 2/13/2006 NJL 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Do; 218 washington tits year Ctr; westminster, MD 21157 Babak Imanael, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Eleve & frede Registrar FEB 1 4 2006

			1 - For State Registrar	State	of Maryla	nd / Depa		of H	ealth a		,		006	061	92
	Physici /Medic		Decedent's Name (First, Midden Regina Richar	_	:t						2. Date of Dea Month Februar	Day	Year 2006	3. Time of (	Death M
)	Examir		4a. Facility Name (If not institution  Carroll Hosp	on, give street and n	umber) er		We	stmi	Location o	f Death		4c. Co	unty of Death	1	
	Funeral Director		5. Social Security Number  493–20–6717  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ ★		80 Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year) 9 192		place (State or intry) IC	Foreign Wa
	deeth with the Maryland ms 23a or 28a-f ehow rroust be rediffed at	tor	10a. State 10b. Count	roll	10c. C	ity, Town or Lo Westmi								10d. Inside City 1 ☐ Yes	
	th with the 23e or 28	al Director	10e. Street and Number 225 Frock Dri	ve	•		10f. Zip (		L <b>1</b> 57			10g. Citizen	of What Cou	intry?	
0-00-0	i 72 hours after deeth with the Marylar "natural", or Itema 23e or 28e-f ehow closi Exercitær mast be collined at	by Funeral	11. Marital Status  1 Never Married 2 Ma 3 X Widowed 4 Divorce	rried 1 Yes	2 XNo Sive		Was Decede f Yes, speci 1 Yes 2		spanic Orig n, Mexican Specify:	in? (Spe , Puerto	ecify Yes or No- Rican, etc.)	1	Race - Amer Black, White ecify:		
1213-0	within 72 h ene. than "natu	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed College	1) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	k done di	uring most	of worki	ng	16b. Kind	of Business/I	ndustry	
ylandz	ould be filed a Mental Hygie arked other atic event, it	To Be Co	17. Father's Name (First, Middle  Edward Richa			J	iomema				(First, Middle, Orkman		wn Hom mame)	e	
e, mar	s 1 end 2 sho f Heelth and Item 27 is m other treum		19a. Informant's Name/Relation Robert W. Stre		20h		4 Old	Wes	stmins	ster	Rd., 1 8/2006	Westm		, MD 21	157
шш	nit. Peges ertment of ortent: If It Injury or o		1 Burial 2 Cremation 4 Donation 5 Other (	Specify)	n State	cemetery, crer rrison	natory or oth	t Ve	t. Ce	em	872000			lls, MD	
Ď	Dep dus dus de de de de de de de de de de de de de		23a. Part1. Enter me disease, o	r complications that	caused the dea	E	ritts	Fun	eral	Home	e and Cl d Westr or respiratory arr	napel minste	P.A.	21157	
j	Physician /Medical Examiner		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. END Due to	STAU-E o (or as a conse	quence of):								Interval Betw Onset and Do	eath +hs
,0070	Medical Examiner Assignment		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CHG	Of or as a conse	STRUCT						SE		2 Mon	
O. DOX 00	w requires thet the death certifica been signed by the ettending ph should be deteched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregr birth 2 Fet gnant at time of mown	al death 3	Ectopic pre				10	23d.	Date of delin		ear .
ras, r	requires thet the reen signed by th hould be deteche	٥	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying ca	use give	n in Part I.			bacco use d		the cause of de bably 4 Ur	
Ital Recor	The le ste hes pege 2	e Completed									24a. Was a autops perfor 1 Yes	SV -	4b. Were aut prior to co death? 1 ☐ Yes	opsy findings at ompletion of car	vailable use of
5	Physicien: r this certific			Hospital: 1 [28a. Date (Modigation	Inpatient 2 [ e of Injury with, Day Year)	ER/Outpatien 28b. Time of Injury		Other	r: 4 □ Nur	rsing Hor	(Check only or ne 5 - Residence 28d. Describe he	ence 6 🗆		ty)	
	pital or Atte	l Certification;	3 Suicide 6 Could 4 Homicide deten	nined 286. Plac buil	ce of Injury - At I ding, etc. (Spec	ity)		17			28f. Location (Si City or Town	n, State)			өг,
	To the Hospital within 24 hours e To the Funerel i completely filled	Medical	29a. Certifier 1 Certifyi (Check only one)  29b. Signature and title of certifie		basis of examin	ation and/or in	estigation, i	t the time in my opi	inion, deat	d place, a	ed at the time, d	ate and pla	d manner as a ce, and due to gned (Month)	o the cause(s)	
•			30. Name and address of person	100/	use of shath (its	m 23e) (Tyo)	1			?	1				
	CRU Sta		ALEXANDER B 31. Date filed (Month, Day, Year	06DASCH 32.	EWSKI Registrar's Sign	ature XI	20	Locy	ST LI	4NE	SUITE	201	WES	TMINSTE	R,Mi
	Registr	ar	FFB	0 8 2006	P. Ballier	J 14	Good	1							

			For State Registrar	State of M	laryland / Dep Ce	partment of Fertificate of		Re	g. No. U U 6	06193
	Physicia	20	1. Decedent's Name (First, Middle					2. Date of Death Month 02	Day Year	3. Time of Death
	/Medic	al	Frances	Sheets	Sutton			1		6 9:10a <sup>™</sup>
	Examin		4a. Facility Name (If not institution Ellicott City				r Location of Death		4c. County of Deal	
			5. Social Security Number		ige (In yrs. last birthda			-		
	Funeral Director		232-42-4254	1 M 2 M F	77 Yrs.	Months Days	Hours Min.	(Month, Day, 02-07-		hplace (State or Foreign untry) Ohio
*			Usual Residence of Decedent					02 07	1,525	OIIIO
	rylan how		10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	Ba-f e	Director		timore	Mill					1 ☐ Yes 2 ☐XNo
	th with the 23a or 23		3701 Rockd	ale Road		10f. Zip Code 21	102	10	g. Citizen of What Co USA	untry?
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow dical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marr  3 ☑ Widowed 4 □ Divorced	If Yes Give	] No	I. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 € No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	hour fural	edp		t's Education		edent's Usual Occup	pation	1	6b. Kind of Business/	Industry
5	n na n na	Completed	(Specify only highes	St grade completed)  College (1-4or	(Giv	re kind of work done DO NOT use retired	during most of work	king		,
212	d within piene. ir than	E	Elementary/Secondary (0-12)	College (1-40)	(5+)	Homemake	er		Own Ho	ome
b	be filed tal Hygind other event, Il	Be C	17. Father's Name (First, Middle, Porter	Sheets			18. Mother's Nam	e (First, Middle, M		
<u>la</u>		2	ggers							
Maryland	and and sm		19a. Informant's Name/Relations						City or Town, State, 2	
	C = 01 L		Nancy Smith	- Daugnte		JI ROCKO			s, MD 21	
Baltimore,	100		20a. Method of Disposition  M☐ Burial 2 ☐ Cremation	3 Removal from Stat	cemetery, ci	ematory or other plac	ce)		Oc. Location - City or	
tim	그는 분들		4 Donation 5 Other (S			ns Of Fai			Baltimor	
Bal	Dermi Depa Impo any i		21. Signal of Funeral Service	HI D	MO0550				neral Hom	
20	een militari ja		23a. Part1. Enter the disease, or	complications that cause	ed the death. Do not e					Approximate
	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	SE	PSis				Interval Between Onset and Death
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	cate be executed oblysician and the burial-transit	Examine	Cause (Disease or injury that initiated events	<b>S</b> .	ESR	0				
ó	exec an an rial-tr		resulting in death) Last	Due to (or a	is a consequence of):					
8760,	ate be nysici	Icai		d						
Box 6	death certifi e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death	B Ectopic pregnancy	y		23d. Date of del Month	ivery Day Year
P.0	that the de ed by the detached	Phy	9 Unknown		had a share the the		ora in Daniel	220 Did tob	acco use contribute lo	the source of death?
Records,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	MTIC Geath	but not resulting in the	underlying cause giv	ven in Part i.		s 2 No 3 Pr	1
ec.	e law re has be	Completed	Fail	re Toil	hive			24a. Was an autopsy	prior to	topsy findings available completion of cause of
<u> </u>	T ate	Son						perform 1 ☐ Yes 2	ed? death? □ 1 Yes	2 🗆 No
Vital	ician: certific rector,	Be	25. Was case referred to medica examiner?					th (Check only one	)	
of \	Physician: this certific ral director,	မ	1 Yes 2 Ho	Hospital:			4 Nursing H		nce 6 Other (Spe	cify)
n	ding P. Atter tuner	o	1 Natural 5 ☐ Pendir		ijury 28b. Time Day Year) Injury	Wor	rk? Yes 2□No	28d. Describe hor	w injury occurred	
Division	or Attenities deat Director: in by the	Certification:	2 Naccident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of I	njury - At home, farm, etc. (Specify)		,	28f. Location (Str City or Town,	eet and Number or Ri State)	ıral Route Number,
u	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director:	edicai Ce	29a. Certifier -1 Sertifyir (Check only one) 2 Medical	ng Physician: To the bes	of examination and/or	ath occurred at the tir investigation, in my o	me, date and place, opinion, death occur	and due to the ca	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the To the Comple	Med	29b. Signature and title of certifie	and manner	orated.	29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
	F 3 F 8		1000 -	J. JAMA	Ending M.	0 0	50373		2/10/	6
1.	20		30. Name and address of person	who completed cause of	death (Item 23a) (Typ	e. Print)	3010)	5	1 11	Goda
1	6		405 Freder	imnd s	10162	Cotonsi	1/6212	28 KX	10110 F	MAC
	Sta Registi		31. Date filed (Month, Day, Year)	0 2006 <sup>32. Rev</sup>	strar's Signature	Sperke				

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Donald February 12, E1wood Skipper 2006 8:30 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital Oak Land Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours 1⊠M 2□F Director 217-28-0558 74 May 20, 1931 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Skipper's Lane 21550 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No <u>م</u> Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed wrum....n and Mental Hygiene... Elementary/Secondary (0-12) College (1-4or 5+) 12th Accountant Hardware Store other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward C. Skipper Pear1 Winters 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health lem 27 i 125 Skipper's Lane, Oakland, Md. 21550 Thelma Skipper/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important; if it any injury or o ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Oakland Cemetery 2/16/06 Oakland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 32 S. Second st. STAN Stewart Funeral Home Oakland, Md. 21550 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sudden Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Years CAD Sequentially list conditions, if any, leading to immediate cause. Enter Under vin Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2ER/Outpatient 3 DOA this funeral 27. Vanner Ceath 28a. Date of Injury (Month, Day Year) 8b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 A atural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 0 153 ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 4th St., OAKLAND, MD 21550 Thomas G. Johnson M.D. 311 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 6:18 p <sup>м</sup> 10, 2006 Arnold William Snyder Feb. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number, **Examiner** Glen Burnie Anne Arundel 101 7847 Americana Circle, If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1**√** M 2□ F 94 NJ Director 144-05-2063 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 101 21060 7847 Americana Circle, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Industrial 4 Accountant .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if Itam 27 is markad othar t jury or othar traumatic evant, th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Millie Nunn Elmer Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, MD 21060 Jennie Snyder/Wife 7847 Americana Circle, 101 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Feb. 16, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Port Murray, NJ 2006 `4 ☐ Donation 5 ☐ Other (Specify) Port Murray Cemetery 22. Name and Address of Facility 21. Signal of Fup al Service Licensee Barrancp & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op ach line. Approximate Interval Between Onset and Death Cardioluscular Immediate Cause (Final herosclorotic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a currequience of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physicien for use as the buria Box 68760 Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ chsease pe bsmuch il tulmonain 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed Mruni ( aroma 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After t Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2,2006 OCTU of person who completed cause of death (Item 23a) (Type Print)

DHMH 17 Rev 1/2001

State

Registrar

e and address

TEARDO 31. Date filed (Month, Day, Year)

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32. Redistrar's Signature

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			1 - For State Registrar	of Maryland	-	artment of rtificate o			ntal Hygie		06197
	Dhysisi		Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day Y	3. Time of Death
	Physici /Medio		Luz Sabasa					F	ebruary	10, 20	06 12:43 a <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give street and r 2335 Dartmouth Lane	number)		, ,	n, or Location o	of Death		4c. County of Anne	Death Arundel
	Funeral Director		5. Social Security Number 230−23−2730 6. Sex 1 □ M 2 🗆 F	7. Age (In yrs. Ia 82	st birthday) Yrs.	If Under 1 Yes Months Day		Min.	Date of Birth (Month, Day, Yo ct. 15,	ear) 1923	Birthplace (State or Foreign Country) Philippines
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Many	to	MD Anne Arundel			Croft	on				1 ☐ Yes 2 ☑ No
	r 28e	irec	10e. Street and Number			10f. Zip Code	Ð		10g.	Citizen of Wha	at Country?
	th with	a D	2335 Dartmouth Lane			1 2	21114			USA	A
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28e-1 show any njury or other traumatic event, the Medical Exam and must be notified at ance.	by Funeral Director	Armed	ecedent Ever in U.S Forces? s 2 🔯 No Give Dates:	1	Was Decedent of f Yes, specify Co 1 ☐ Yes 2 15 N		gin? (Specify , Puerto Ric	Yes or No- an, etc.)	Black,	American Indian, White, etc. Filipino
20	72 ho	eted	15. Decedent's Education (Specify only highest grade completed	4)		lent's Usual Occ kind of work dor		t of working	168	b. Kind of Busin	ness/Industry
2	ithin 189.	Completed		(1-4or 5+)	life. I	OO NOT use ret	ired)	or working			_
	lygier her th		12			Homema					Home
Maryland	ould be fi Mental H arked of	To Be	17. Father's Name (First, Middle, Last)  Lorenzo Greffaldeo, Si	r.			Cat	alina	irst, Middle, Mai Guarin		
	and 2 sha salth and n 27 is m		19a. Informant's Name/Relationship (Type, Print)  Josephine Sabasa/Daugh	nter			outh La	ne, Cı	oute Number, Co cofton,		
Baltimore,	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from  4 ☐ Donation 5 ☐ Other (Specify)	n State Cer	netery, cren	sition (Name of natory or other p L1 Cemet	ery	Feb. Date 2006		E. Location - City Brookly	y or Town, State
Balt	permit. Departr Imports any nju		21. Signature of Funeral Service Licensee		B 40	Name and Add Arranco 5 Gov.	ress of Facility & Sons Ritchie	P.A.	Severn	a Park a Park,	Funeral Home MD 21146
18760,	/Medical Examiner  bhysician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events . c.	o (or as a conseque	ance of):	sind.	ma	les	Hlar	ng	7 Mohal
.O. Box 68	death certifi e attending ed for use as	Physician/Medic	in the past 12 months?	outcome of pregnand birth 2 Fetal of gnant at time of dea known	leath 3	Ectopic pregnar Other (specify)				23d. Date of Month	f delivery Day Year
٥.	The law requires that the ate has been signed by th page 2 should be detache	by	Part II. Other significant conditions contributing to	death but not result	ing in the ur	derlying cause	gıven in Part I.		23e. Did tobace		te to the cause of death?
Vital Records,	The law requirate has been page 2 shoul	Completed	Seizure 9	Disc	red	er,	,		24a. Was an autopsy	prior	e autopsy findings available
<u>=</u>	r: Th		Rexun )	esop	na	gue	2		performed	? deat	Yes 2□ No
Ž.	Physicien: Th this certificate ral director, pag	Be	25. Was case ref d to medical examiner?	<i>U</i>	(	1	)ther		heck only one)		Daushter
	ding Phys	ion; To	27. Manner of Death 1 Natural 5 Pending (Mo		P/Outpatient 8b. Time of Injury	28c. In	jury at fork?	28d.	5 Residence Describe how in	-	Specify) Hemo
Division of	or Attendater deat Director: in by the	Certification;		ce of Injury - At hom ding, etc. (Specify)	e, farm, stre		□Yes 2□N æ	_	Location (Stree City or Town, S		or Rural Route Number,
	To the Hospitel within 24 hours To the Funeral completely filled	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the property of the and many one)	ne best of my know basis of examination	edge, death n and/or inv	occurred at the estigation, in my	time, date and y opinion, death	d place, and h occurred a	due to the cause tt the time, date	e(s) and manne and place, and	or as stated. due to the cause(s)
<b>)</b>	To the within To the comp	ž	29b. Signature and title of certifier  Servarding	a an	m	29c. Lice	onse number	581	29d.	Date signed (N	Month, Day, Year)
			30. Name and address of person who completed ca	use of death (Item 2	(3a) (Type, I	Man A	Lof	Ani	V Si	into	230
	Sta Registr	-	31. Date filed (Month, Day, Year) 32.	Redistrar's Signatu	re de	10 4/10	1/00(	22	Ein F.	run	re, mil

State of Maryland / Department of Health and Mental Hygiene [] [] [ For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9 , Month **Physician** a M J. Sampogna February 2006 8:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sandy Spring Montgomery Friends Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo Nov. 29, 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In vrs. last birthday) 5. Social Security Number Year) **Funeral** Months Days Hours 1 X M 2 □ F 577-26-6968 81 1924 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 27 is marked other than "natural", or items 23s or 28s-f shor troumatic event, the Marical Exporter national be notified at Montgomery Silver Spring 1 ☐ Yes 🏞 No Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 14510 Homecrest Road, Apt. 4016 e tiled within 72 hours atter death all Hygiene. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No 1 Never Married 2X Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Year or Dates: 1943-46 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Improvements 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be till iment of Health and Mental H lent: If Item 27 Is marked ott Annamarie Giannantonio Domenico A. Sampogna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14510 Homecrest Road, Apt. 4016, Silver Spring, MD Helen T. Sampogna/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition February 13, 1 Burial 2 Cremation 3 Removal from State injury or Department of Importent: If any injury or once. Gate of Heaven Cemetery 2006 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Cancer 9 Months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certiticate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ò 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f been signed is should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by Hairy Cell Leukemia, Clostridia Difficile Colitis, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes, Hypertension autopsy performed? Yes 2 No page 2 1 Yes Division of Vital Hospitel or Attending Physicien: director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending To the Funeral Director: Africa to the Funeral Director: Africad in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 10, 2006 D18726 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arthur Schoengold, M.D. 18111 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature 14 2006 Registrar

			For State Registrar		Sta	te of M	aryland		artmen rtificate				ental Hy	giene Reg. No.	06	0619	99
		.5	1. Decedent's Name	(First, Middle	, Last)								2. Date of Dea	ath Day	Year	3. Time of	Death
	Physicia /Medic		Daphne	Dahl	Rowe	Sar	ıdin		,				Februa	ry 9,	2006	5:55	p <sup>M</sup>
× .	Examin		4a. Facility Name (If	not institution,	give street a	und number)			4b. City,	Town, or	Location of	of Death		4c. C	ounty of Dea	ath	
			Casey Ho	use						kvi1					ntgome		
1	Euneral		5. Social Security N	umber	6. Sex 1 ☐ M 2	-	je (In yrs. la	ast birthday)	If Under Months	1 Year_ Days	If Under Hours	Min.	8. Date of Birl (Month, Da	y, Year)		rthplace (State of Country)	
3	Director	=	043-26-7		1   101 21	231		71 Yrs.					April	10,19	34 Cor	nnecticu	t
	pug *		Usual Residence of 10a. State	10b. County			10c. City	, Town or Lo	ocation							10d. Inside Cit	y Limits
	eho	5														1 ☐ Yes	2 🔼 No
	the N	Director	Maryland	Montg	omery		Koci	cville	10f. Zip	Code				10g. Citize	n of What C	Country?	
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	eath	Funeral	4408 Have	riora		is Decedent	Ever in U.S	S. 13.	_			igin? (Spe	cifv Yes or No		. Race - Am	erican Indian,	-
	Item Item	Š	1 Never Marri	ed 21⊠ Marri	Arr	ned Forces? Yes 2K	,		If Yes, spec	offy Cuba			cify Yes or No Rican, etc.)	-	Black, Wh	ite, etc.	
99	irs af	þ	3 Widowed		If Y	es, Give ar or Dates:			1 🗌 Yes	2 <b>⊠</b> No	Specify:			S	pecify: Wi	nite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Items 23a or 28a-f ehow ent. It a Medical Examinar must be mutified at	Completed		15. Decedent				16a. Dece	dent's Usua	al Occupa	ation	A = 6		16b. Kind	of Busines		
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פַ	othe vent.	Be	17. Father's Name	(First, Middle,	Last)						18. Mothe	er's Name	(First, Middle,	, Maiden S	u <i>m</i> ame)		
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Maryland	ema • ma		19a. Informant's Na	ame/Relations	hip (Type, Pri	int)			•				Route Number				
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Sre	1 3 2 2 2 V		20a. Method of Disp		2 □Remove	al from State	20b. PI	ace of Disponentery, cre	osition (Nar matory or o	ne of other plac	(9)	D	ate	20c. Loca	ation - City o	or Town, State	
Ĕ	Pag Int. I		4 Donation			ai iioiii State	Ft.	Linco	ln Cr	emat	ory	2/15/	2006	Bren	twood	, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Fu	neral Service	Licensee			Si 10	2. Name ar .mple 140 Rc	Trib ckvi	ss of Facility oute 1 111e 1	r Funer Pike;	al and Rockv	Crem	ation Maryl	Center land 208	52
۲	W. 4		23a. Part1. Enter the shock, or hea	he disease, or	complication	s that cause	d the death									Approximate Interval Bet	e ween
п	Physician		Immediate Cause	(Final		ecurr										Onset and I	Death
	/Medical		disease or condition resulting in death)	ori	a	Due to (or as			ııa						<u>-</u>		
0.0	Examiner			21.1	ь. <u>Е</u>	nd Sta	age Cl	hronic	Obst	ruct	ive 1	Pulmo	nary D	iseas	e		
100		Jer	Sequentially list co if any, leading to in cause. Enter Unde	nmediate		Due to (or as							_				
	cuted nd ransil	Examiner	Cause (Disease or that initiated events	injury	c												
oʻ	te be executed ysicien and te burial-transit	E	resulting in death)	Last		Due to (or as	a consequ	uence of):									
3760,		Ical			d					_							
89	ng ph ng ph as t	Med	IF FEMALE:														
Вох	es that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	23b. Was deceden		10	yes, outcome ⊒Live birth	2 Fetal	death 3	☐Ectopic p	regnancy	,			23	ld. Date of d Month	-	Year
о. П	a dea he at led fo	sici	1 ☐ Yes 2 ₽	<b>⊠</b> No		□Pregnant a □Unknown	t time of de	eath 5	Other (sp	oecify)						/	
Ρ.	The law requires that the ste has been signed by th bage 2 should be detache	P.	Part ff. Other signif		ann anntábuti	na to dooth i	but not rose	ulting in the s	undoshina a	201100 0111	on in Bod		23e Did t	obacco use	e contribute	to the cause of d	eath?
	res th		Pait II. Other signi	neam conditi	Aris Contributi	ing to death	Dut not rest	and girt the t	andenying c	Ause GIV	on ar arc	1.		Yes 2		Probably 4 □L	
orc	w require been sig should b	Completed											+	1			100
ec	law lasb	npie											24a. Was		24b. Were a prior to death?	autopsy findings o completion of c	available ause of
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Vital Records,	ysician: Th is certificate director, pag	Be	25. Was case refer examiner?	rred to medical	Hospita	al:				Oth			(Check only			77	
jo	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ 27. Manner of Deat			1 🔲 inpat		ER/Outpatie 28b. Time (		JA	4 🗆 NI		ne 5 Resi			Decity Hospi	ce
ň	Ing When	o	1 XNatural	5 🗌 Pendin	9	a. Date of fnj (Month, D	ay Year)	Injury	м (	28c. Injur Wor	k? Yes 2.⊡		SOU DESCRIBE	now injury	occarroa		
Sic	Attending r death. ector: After by the fune	cat	2 Accident 3 Suicide	investig 6 🗌 Çould	not be	e. Place of Ir	iury - At ho	me farm s					28f Location /	Street and	Number or I	Rural Route Num	iber.
Division	Hospital or Attendi 24 hours after death. Funeral Director: A stely filled in by the fi	Certification:	4  Homicide	determ	nined 200	building, 6	tc. (Specify	/)	reet, ractor	y, onloc			City or To				
	Hospital 24 hours a Funeral I	Ö	29a, Certifier	1X Certifyin	ng Physician	: To the bes	t of my kno	wledge, dea	th occurred	at the tir	ne, date a	nd place, a	and due to the	cause(s) a	nd manner	as stated.	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only one)	2 Medical	Examiner: O	n the basis nd manner s	of examina	tion and/or i	nvestigation	n, in my o	pinion, dea	ath occurre	ed at the time,	date and p	place, and di	ue to the cause(s	)
	To the I within 2 To the I complet	Me	29b. Signature and	title of certifie					29	c. Licens	e number			29d. Date	signed (Mo	nth, Day, Year)	
			1	KI	_	*	20		-	D 2	56	25		Februa	arv 10	2006	
	12		30. Name and add	ress of person	who complet	ed cause of	death (Item	1 23a) (Type			6						
			Joseph Ka							Rocky	ville	, Mar	yland	20855			
	Sta	ite	31. Date filed (Mor	nth, Day, Year)		32 Regis	trar's Signa	ture	ashi				-				
	Regist	ar	F	EB 14	2006	J. D. Con	a h	1 19	AND THE PERSON NAMED IN								

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9 TYNES FEBRUARY 2006 10:50 A LUCILLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FUTURECARE PINEVIEW NURSING HOME CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Funeral 1□M 2⊠F 93 Director 223-18-2429 DECEMBER 25 VIRGINIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show other traumatic event, the Medical Exactinar must be notified at MXYes 2 □ No Director M PRINCE GEORGE'S TEMPLE HILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 5003 WILKINS DRIVE 20748 U.S.A. itame 23a filed within 72 hours after death Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2√ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by BLACK 3 XWidowed 4 ☐ Divorced "naturai", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) TEACHER GOVERNMENT 4 other 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental I GEORGIA SEWARD EDMUND MITTER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5003 WILKINS DRIVE TEMPLE HILLS, MARYLAND JOHN R. HARGRAVE/SON item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if it eny injury or o ō 1 Burial 2 □ Cremation 3 □ Removal from State 2/15/2006 NORFORK, VIRGINIA CALVARY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): ettending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à cete has been signed page 2 should be 2X No 3 ☐ Probably 4 ☐ Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2⊠No 2**1** No certificate 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 412 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 [X No 2 ER/Outpatient 3 DOA Certification: To his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending death. 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10, 2006 D-18545 FEBRUARY -11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP WISOTSKY M.D. 12070 OLD LINE CENTER SUITE 207 WALDORF, MARYLAND 20602 2. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 1 4 2006 Registrar

			For Stete Registrar	State of	Maryland		artment rtificate			nd Me		iene eg. No.	106	062	02
1	Physici	an	1. Decedent's Name (First, Middle								Date of Dear	Day	Year	3. Time o	
	/Medic	_	Dorothy Berry								Februai	CA 1	2006		80 a <sup>M</sup>
	Examin	er	4a. Facility Neme (If not institution		ber)		4b. City, To					40.0	County of Deat		
51	Funeral	- 60	5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1	Year	If Under 2	24 Hrs. 8. Min.	. Date of Birth	Vearl	Carro]	hplace (State	o <i>r Forei</i> gn
*	Director		215-12-4665 Usual Residence of Decedent	1 □ M 2 🔭	9	1 Yrs.	Months	Days	Hours	I I	Date of Birth (Month Day March	1 19:	14	untry) N	1D
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside (	City Limits
	f eho	ō	MD C	arroll		West	minst	er						1 ☐ Yes	s 2 No
	r 28a	Director	10e. Street and Number				10f. Zip 0				1	0g. Citiz	en of What Co	untry?	
	th with	alD	20 Bond Street	t				211	.57			τ	JSA		
	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or Items 23e or 28e-f ehow svent, the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed For		S. 13.	Was Decede If Yes, specif	ent of His fy Cuban	panic Orig , Mexican,	in? (Specif Puerto Ric	fy Yes or No- can, etc.)	1.	<ol> <li>Race - Ame Black, White</li> </ol>		
36	rs afte	by F	1 Never Married 2 Marr  XXWidowed 4 Divorced	If Yes, Give	9		1 🗆 Yes 2	No No	Specify:			5	Specify:	White	
21215-0036	2 hou	ted	15. Deceden	t's Education		16a. Dece	dent's Usual	Occupa	tion	-6		16b. Kin	d of Business/	Industry	
215	thin 7	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	kind of work DO NOT use	retired)		or working		G 11	m1-		T
7	ygien ygien her th	Con				(	Chairw	-		de Nome //	Time Address		. Tevis	& Son	i, Inc
and	i be fi	Be	17. Father's Name (First, Middle,								First, Middle,				
Maryland	should ind Men ind Men ind marke	2	Charles Kinley  19a. Informant's Name/Relations			19b. Maili	ng Address (				uerite Route Number		C <b>Z</b> Town, State, 2	Zip Code)	
	and 2 saith ar n 27 is		Stanley H. Tevis	s III/son		405 (	Cassel	1 C1	ose	West	minste	c, MI	2115	57	
Baltimore,	- 7 5 5		20a. Method of Disposition  1X Burial 2 Cremation	2 Domoust from 9	20b. PI	lace of Dispo	sition (Name matory or oth	e of ner place	)	Date	9	20c. Loc	ation - City or	Town, State	
Ĕ	Pages ment of the ant: If the lury or of		4 Donation 5 Other (S										ninster	, MD	
3alt	permit. Departr Imports any inju		21. Signature of Funeral Service	Licensee							and Cha				
344	40 = 60		23a. Part1. Enter the disease, or	complications that ca	used the death						Westmi		er, MD	21157 Approxima	ate
20.5	Dhusisian		shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ich line.	A.	^							Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a. Due to	ores a consequ	uence of):	(me	un	m	الــــــــــــــــــــــــــــــــــــ				Zul	1
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	D tis	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a consequ	uence of):	- 500							0	
_	and and II-tran	Examiner	that initiated events resulting in death) Last	, c. Due to (	or as a consequ	uence of);									
8760,	icate be executed physician and s the burial-transit	alE													
9	g phy as the	Physician/Medical		0.								1			
Вох	endin r use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		Ectopic pre	onancy				23	3d. Date of del	-	W
	e deal	slcia	in the past 12 months? 1  Yes 2 No 9 Unknown		ant at time of de		Other (spe						Month	Day	Year
P.0	law requires that the death certific as been signed by the attending p z should be detached for use as:	Phy	Part II. Other significant condition	ons contributing to de	ath but not resu	ulting in the u	nderlying car	use cive	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of	death?
ds,	signe Id be	d by	Question.				, , , , ,	grad			1 🗆 Y				]Unknown
cor	w require been si should	lete	21,2								24a. Was a	n	24b. Were au	itopsy finding	s available
Re	The lay	Completed									autops perfor	med?	prior to death?	completion of	cause of
ita	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medica	1					26. Place	of Death (	Check only or		12,703	20110	
of Vital Records,	Physician: this certific ral director,	To	examiner? 1 Yes 2 No			ER/Outpatie		Othe	r: 4 🗆 Nur				□Other (Spe	cify)	
	ding P. h. After t funera	lon:	27. Manner of Death  Natural 5 ☐ Pendir	.9	of Injury th, Day Year)	28b. Time o Injury		Work	?		d. Describe h	ow injury	occurred		
Division	l or Attending after death. Director: Afte In by the fune	licat	2 Accident investi 3 Suicide 6 Could	not be	of Injury - At ho	me, farm, st	M reet factor.		′es 2□N		f. Location (S	treet and	Number or Ru	ural Route Nu	mber.
<u>≤</u>	atter Direct	Certification:	4 ☐ Homicide determ	buildir	ig, etc. (Specify	)					City or Tow	n, State)			
	To the Hospital or Atlending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier Certifying (Check only	Physician: To he	best of my know	wledge, dead	n occurred a	t the time	e, date and	d place, and	d due to the c	ause(s) a	and manner as	stated.	(c)
	the Hi in 24 the Fi	ledical	one)	Examiner: On the ba	er stated.	lioty arituror in				ii occurred					(2)
	**	Σ	29b. Signature and title of certifie		61		29c.	License	number	_			signed (Mont		
,	WJL			( )		Y	Poline)	り	144	4		rel	n 100	1200	16
	30		30. Name and address of person	who completed caus	e of death (Item	3a) (Type,	Print)	de.		S	1-20	11 6	n 10th	la 1	1440
Agg.	Sta	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signal	ture			en e	الله الله		V		wen, I	-VV ]
100	Regist		FEB 1	3 2006	Roser	B.	Coaste	1							

Ce	ertificate of		ental Hygi	g. No.	06203							
1. Decedent's Name (First, Middle, Last)  Physician Charles Ervin Thomas			2. Dete of Death Month Februar	Dev Ye	3. Time of Death							
/Medical Examiner  4a Fecility Neme (If not institution, give street end number)		4b. City, Town, or Lo	cation of Deeth	4c. County of I	Death							
Goodwill Mennonite Home  5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday		Grantsvil		Garrett								
Director 243220193 1⊠ M 2□ F 82 Yrs.	Months Days	Hours Min.	Month, Dev. March 27	, 1923 M	Birthplece (State or Foreign Country) laryland							
Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation .				10d. Inside City Limits							
MD Garrett Friendsv  10a. State 10b. County 10c. City, Town or L  MD Garrett Friendsv  10b. Street end Number 1.571 Frazee Ridge Rd.	ille				1 ☐ Yes 2√∑ No							
10e. Street end Number	10f. Zip Code		10	g. Citizen of Whe	t Country?							
1571 Frazee Ridge Rd.	21531			SA								
1 Never Married 2 Married 1 Ves 2 Si No If Yes, Give 3 Si Widowed 4 Divorced Year or Dates:	. Was Decedent of F If Yes, specify Cub- 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc. White							
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)  16b. Decedent's Education (Givenity only highest grade completed)  16c. Decedent's Education (Givenity only highest grade completed)  Weld  Weld	edent's Usuel Occup	etion during most of worki	na 1	16b. Kind of Busin	ess/Industry							
Elementary/Secondary (0-12) College (1-4or 5+) Weld		during most of working)		[1] a ] d d m m	0							
Weld 17. Father's Neme (First, Middle, Last)	er/Superv	isor 18. Mother's Name		Welding	Company							
Cogil Whomas		Rhubena 1										
	ling Address (Street	and Number or Rure	I Route Number,	City or Town, Sta	te, Zip Code) 44035							
Joseph C. Thomas/Son 900	Hunters C	rossing D										
Cemetery, cre	position (Neme of emetory or other pla ing Cemet			006 Frie	y or Town, State endsville, MD							
	22. Name end Addre	ss of Facility Ne			omes, P.A.							
23a. Part1. Enter the diseese, or complications that caused the death. Do not en shock, or heart ailure. List only one ceuse on each line.					Approximate Interval Between Onset and Death							
Physician  /Medical Immediate Cause (Final disease or condition resulting in death)  Examiner Tesulting in death)  Dementia, sending in death)	ile onset				5 years							
Due to (or as e conse	equence of):											
Due to (or as a conservation of the conservati	equence of):											
cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conse	equence of):											
Part II. Other significant conditions contributing to death but not resulting in the atherosclerotic cardiovascular dis												
Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ren in Part I.	23b. Did tol	bacco use contri	bute to the cause of death?							
atherosclerotic cardiovascular dis	ease		1 □ Ye	s 2 XNo 3	☐ Probably 4 ☐ Unknown							
atrial fibriliation			24a. Wes er perform		4b. Were autopsy findings available prior to completion of cause of death?							
The la at a bag a day a			1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No							
		26 Place of Death	(Check only one	a)								
25. Was case referred to medical	examiner?											
	BIL 30 DOA	ner: 4 X Nursing Hor	me 5 Reside	nce 6 DOther (	Specify)							
25. Was case referred to medical examiner?  1	of 28c. Inju	ner: 4 X Nursing Hor	me 5 Reside		Specify)							
25. Was case referred to medical examiner?  1	of 28c. Injur	er: 4 ANursing Hor y et 2 rk? Yes 2 □ No	me 5 ☐ Resider 28d. Describe ho	nce 6 Other ( w injury occurred	Specify) or Rurel Route Number,							
25. Was case referred to medical examiner?  1	of 28c. Injunded Work Months of the street, fectory, office with occurred at the time.	ner: 4 X Nursing Hor ny et rk? Yes 2 □ No	me 5 Resider 28d. Describe ho 28f. Location (Str. City or Town,	nce 6 Other ( w injury occurred  reet and Number ( , State)	or Rurel Route Number, er es stated.							
27. Manner of Death  1 Natural  28e. Dete of Injury  (Month, Dey Year)  28e. Place of Injury - At home, farm, s building, etc. (Specify)  29a. Certifier  (Check only  29a. Certifier  (Check only  29a. Certifier  (Check only  29a. Certifier  (Check only  29b. Time  (Month, Dey Year)  28e. Place of Injury - At home, farm, s building, etc. (Specify)	of 28c. Inju Wo M 1 Carreet, fectory, office at the curred at the tin nvestigation, in my carreet.	Ner: 4 Nursing Hor y et rk? Yes 2 No	me 5 Resider 28d. Describe hor 28f. Location (Str. City or Town, and due to the ca ed et the time, da	nce 6 Other ( w injury occurred  reet and Number of , State)  use(s) and manne ate and place, and dd. Date signed ( M	or Rurel Route Number, er es stated. I due to the cause(s)							
25. Was case referred to medical examiner?    The column   Column	of 28c. Inju Wo M 1 Carreet, fectory, office at the curred at the tin nvestigation, in my carreet.	Ner: 4 Nursing Hor y et k? Yes 2 No	me 5 Resider 28d. Describe hor 28f. Location (Str. City or Town, and due to the ca ed et the time, da	nce 6 Other ( w injury occurred  reet and Number of , State)  use(s) and manne ate and place, and dd. Date signed ( M	or Rurel Route Number, er es stated. I due to the cause(s)							
27. Manner of Death    1	of 28c. Injunctivest, fectory, office at the courred at the time investigation, in my control of the courred at the time investigation, in my control of the courred at the time investigation, in my control of the course of the	ner: 4 Nursing Hor y et k? Yes 2 No me, date and plece, e pinion, death occurred the number 025759	me 5 Resider 28d. Describe hor 28f. Location (Str. City or Town, and due to the ca ad et the time, da	nce 6 Other ( w injury occurred  reet and Number of , State)  use(s) and manne ate and place, and dd. Date signed ( M	or Rurel Route Number, er es stated. I due to the cause(s)							

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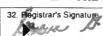
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Charles Howard 2. Date of Death Day 9, 3. Time of Death **Physician** Thomas February 2006 12:05A. M /Medical 9027 48th Place Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** College Park Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. July 16, 1927 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 577-32-6520 78 Marvland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importent: if item 27 is marked other then "natural", or iteme 23e or 28e-f show injuny or other traumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9027 48th Place 20740 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 1942-1962 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 XNo Specify. White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bio Chemical Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clinton Eaton Lucy Louise Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 7037 Mink Hollow Road Highland, Maryland 20777 19a. Informant's Name/Relationship (Type, Print) Jo Jo Montgomery -niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2/13/2006 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of uneral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 austis 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA weeks /Medical Due to (or as a consequence of) Examiner Dificile Colitie Clostridium Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the ettending physicien and should be detached for use as the burial-transit Months The law requires thet the deeth certificate be executed fulmonary Edema Due to (or as a consequence of): years Coronary artery Physician/Medical disease IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive disease Dulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Certification: To 3□ DOA this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 Tes 2 No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

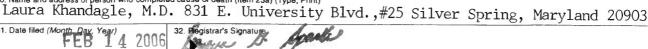
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 D61067 February 9, 2006 Physician

Registrar

14 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H rtificate of I			iene <sub>eg. No.</sub>	06205
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Deat	h	3. Time of Death
	/Medic	al	Charles M. Tramm			4 62 T		February		
	Examin	er	Collington Episcop		g Home	Mitchell	Location of Death $1ville$		Prince G	
	Funeral Director		5. Social Security Number 6. Sec 577-05-7556	7. Age	(In yrs. last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 2 1	9. E	irthplace (State or Foreign Country) .OTICIA.
	pue *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl a-f eho	tor	MI) Prince G	eorges	Mitchell					1√2Yes 2 No
	ith the	Funerai Director	10e. Street and Number	-		10f. Zip Code			0g. Citizen of What	
	s 23a	erail	10450 Lottsford Ro	a.d. 12. Was Decedent E	verial I C to 1	20721	ii- O-i-i-0 (S-		nited Sta	
2-0036	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylend Department of Heatih and Mental Hygiene. Important: If Item 27 te marked other than "neturel; or Items 23a or 28a-1 ehow any Injury or other traumatic event, the Modical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?	03/13/1041	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2ᠯ∑ No	Ispanic Origin? (Sp in, Mexican, Puerto Specify:	Pecry Yes or No- Display Rican, etc.)	Black, Wi	nerican Indian, nite, etc. White
1215-0	ithio 72 ho Je. Ban "netur Modical	Completed	15. Decedent's Edu (Specify onfy highest grade Elementary/Secondary (0-12)	cation	16a. Deced (Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work l)		16b. Kind of Busines	,
2	Hygier Hygier ther th	Col	17. Father's Name (First, Middle, Last)	<b>3</b> +	Lawy	er	18 Mother's Nam	e (First, Middle, N	Governmen	t
Maryland 2121	Aental Aental rked o	To Be	Charles M. Tramme	11				y Robert	,	
lary	2 shou and N le mai		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a	and Number or Rui	ral Route Number,	City or Town, State	, Zip Code)
e,	Health Health Ther tr		Charles M. Trammel 20a. Method of Disposition	1 III / S	on 6212 20b. Place of Dispos	Walhondin			MD 20816 20c. Location - City of	or Town State
altimore,	ages of of the state of the sta		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	natory or other place	θ)			
alti	mit. F partm portar y Injur		21. Signature of Funer I Service License	90	National 22	Cremator  Name and Addres	s of Facility Tos	-2006 F	alls Chur er's Sons	ch, VA
<u> </u>	20E = 3		W. Uff Mun	<del>'</del>	51.	<u>30 Wisco</u>	asin Ave	e NW /	Washingt	on DC 20016
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only do				g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		consequence of):	Failure				
ı	Examiner		Sequentially list conditions,	).						
	ed ssit	niner	It any leading to intrincipate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
<b>,</b>	ficate be executed physicien and is the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
68760,	ate be nysicie he bur	edicai		l						
_		/Med	IF FEMALE:	3c. If yes, outcome o	f pregnancy					
P.O. Box	The law requires that the death certif site has been signed by the attending sege 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	res that the de igned by the a be detached f	by Ph	Part II. Other significant conditions con	tributing to death bu	t not resulting in the un	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ords	w require been sig should b	ted b	Dementia					1 🗆 Ye	s 2√∏No 3□I	Probably 4 Unknown
Vital Records,		Completed						24a. Was ar autopsy perform 1 Yes 2	prior to death?	autopsy findings available completion of cause of
Vita	nysician: Th	Be	25. Was case referred to medical examiner?	ospital:		2□ DOA Othe	No.	h (Check only one	•	
ö	ding Phys h. After this funeral di	n: To	27. Magner of Death	28a. Date of Injury	t 2 EP/Outpatient	28c. Injury Work	42 Nuising no	ome 5 Resider 28d. Describe hor	nce 6 Other (Sp w injury occurred	ecify)
Ö	Attending death. ctor: Afte y the fun	atio	1 Accident 5 ☐ Pending investigation	(Month, Day	Year) Injury		(? Yes 2□No			
Division of	tel or Attendeath	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or I , State)	Rural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2   Medical Examir	sicien: To the best of ner: On the basis of and manner state	my knowledge, death examination and/or inved.	occurred at the tim estigation, in my op	e, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner attended to the and place, and du	as stated. se to the cause(s)
	with To T	Σ	29b. Signature and title of certifier	/	110	29c. License	number		d. Date signed (Mor	
	5		30. Name and address of person who co	moleted cause of de	ath (Item 23a) (Tune E	D476	603	F	Feb 13,200	6
			Dr. William DuBoyo	e M.D. 4	000 Mithce	llve Rd.	Bowie M	mm		
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 1 4 2006	22. Registrar	's Signature	12.1	,			
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ≺

	1	For State Registrar	State of Ma	aryland	•	irtmen <i>tificate</i>			d M		giene Reg. No.	006	06	206
		Decedent's Name (First, Middle,	Last)							2. Date of De	ath			ne of Death
sicia edica	_	CHARLOTTE W	ILLIAMS '	TAYLO	)R					Month FEBRU	Day ARY			о:30₽м
nine		4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or L	ocation of D	Death			County of D		
		CHARLES COUNTY	Y NURSING	& RE	CHAB.	LA	PLA					C	HARLE	S
ral		5. Social Security Number 6		e (in yrs. la		If Under Months	1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. 1	Birthplace (St	ate or Foreign
or		228-22-0695	1□ M 3√3/F	84	Yrs.					MAY 2			IRGIN	
		Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Lo	cation							10d Insid	de City Limits
	.													Yes 2 □ No
	20	MARYLAND CHAI  10e. Street and Number	RLES	<u> </u>	LA PL	10f. Zip	Codo				10a Citi	zen of What		
		10200 LA PLATA	V DOVD				2064	6			rog. Oili	U.S.		
	2	11. Marital Status	12. Was Decedent	Ever in U.S	13 V				2 (Spe	cify Yes or No			merican India	in
١,	듣	1 ☐ Never Married 2 ☐ Married	Armed Forces?	,		Yes, spec	ify Cuban	, Mexican, P	uèrto l	Rican, etc.)			/hite, etc.	,
	ρ Ω	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2	<b>2√_</b> \⁄\o	Specify:				Specify:	BLACK	
	Completed	15. Decedent's			16a. Deced				£ um eki		16b. Ki	nd of Busine		
	음	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT us	e retired)	ring most of	WOIKI	<i>'</i> 9				
	ခွ် မြ	12			COOK							OPLES	DRUG	STORE
	Be	17. Father's Name (First, Middle, La	ist)							(First, Middle		Sumame)		
	ဍ	CHARLES WIL	LIAMS						-	E GAI				
		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street ar	nd Number o	or Rura	l Route Numb	er, City o	r Town, Stat	e, Zip Code)	
	-	MARIAN DICKE	RSON-DAUG		4710			RD.						
		20a. Method of Disposition 1√2√8urial 2 ☐ Cremation 3	Removal from State	ra	metery, cren			1		ate			or Town, Sta	
		4 ☐Donation 5 ☐ Other (Spe			NWO				-25	-2006	HAI	RRISO	NBURG	,VA
		21. Signature of Euneral Service Li	1 AND	M0047	イン	RAYM	OND	of Facility FUNE	RAI	SERV	ICE			
	+	23a. Part1. Enter the disease, or or	omplications that cause	d the death.	Do not ente	LA P	LATA e of dying,	, MAI	RYI rdiac o	AND 2	064 (	<del>5</del>	Approx	
n		Immediate Cause (Final Cause of Final Onset and											l Between and Death	
		disease or condition resulting in death)  Due to (or as a consequence of):												
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		resulting in death) Last	Due to (or as	a consequ	ence of):					·				
	dicai		La. H7	N										
	by Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	icy							23d. Date of	delivoor	
	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic produced of the second						Month	Day	Year
ľ	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown											
	Y P	Part II. Other significant condition	s contributing to death t	out not resul	iting in the ur	nderlying c	ause giver	n in Part I.		23e. Did	tobacco u	ise contribut	e to the cause	of death?
										1 🗆	Yes 21	∑√N₀ 3 [	Probably	4 □Unknown
	Set									24a. Was		24b. Were	autopsy find	ings available
	Completed										ormed?	death	to completion n? Yes 2□ No	
1	0	25. Was case referred to medical						26 Place of	f Death	1 ☐ Yes	2.2/No	1 '0	res ZLINO	
	0 8	examiner?	Hospital:	ent 2 🗆 E	R/Outpatien	t 3 DC	Other			ne 5 ☐ Res		6 ∏Other (S	Specify)	
	ı.	27. Manner of Death	28a. Date of Inju	Jry Jry Year)	28b. Time of	2	8c. Injury	at		28d. Describe			,	
	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga		ly rear/	Injury	м		es 2 □No	,					
	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of in	jury - At hor		eet, factory	, office		:	28f. Location ( City or To			r Rural Route	Number,
	Certification:		- 21											
1	ledical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of	of examinati	on and/or inv	estigation.	, in my opi	nion, death (	occurr	ed at the time.	date and	place, and	due to the car	Ise(s)
1	Med	29b. Signature and title of certifier	and manner st	ialeU.		290	. License	number			29d. Da	te signed (M	lonth, Day, Ye	20607
		1 mil	M	D			DOO	579	790	7	17	2/22/	06	
		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type.	Print)						1 ,		- / ~-
		Manisha Jan	i Wala, MD	1163	7 Te	rrac	e D	sive,	SF	e 103	Wa	day	MD.	20602
itai		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ure Ana	Sept 1								
iistra	ar	MAR n 1 2	HIN FINANCIAL	J. J. J. J.	Day of the same of	100								

iciar	· .	1. Decedent's Name (First, Middle, L	~	FH PGC cr	-	rtificate of	DOU	2. Date of De	Reg. No.	UUb	3. Time of Death
dica	n		yrone	William	ns			Februa.	Day	2, 2006	8:25 A
nine	r	4a. Fecility Name (If not institution, g 225 Panorama Dr.		mber)		4b. City, Town, o	Hill			P.G.	
al or		5. Social Security Number 6. 578–60–3665  Usuel Residence of Decedent	Sex 1 M 2 F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year   Months   Days		Min. 8. Date of Bi (Month, Date of Bi (Month, Date of Bi		Cou	pleca (State or Foreintry)  ngton, D.C.
		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limi
ODGS. To Be Completed by Enneyel Director	Director	MD PG  10e. Street and Number			Oxon Hi	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10a Citi	izen of What Cou	1 Yes 2 N
2	2	225 Panorama Drive				20745			-	USA	,
	by Funeral	11. Marital Status  1 ☐ Never Married 2☑ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 No ve A			lispanic Originan, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ameri Black, White, Specify: Pla	, etc.
potolog	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most o	f working	16b. Ki	ind of Business/In	ndustry
2	5 -	12th		,	]	Forman				rack	
Q	0 20	17. Father's Name (First, Middle, La.		Williams				Name (First, Middle Ewkins	, Maiden	Sumame)	
		19a. Informant's Name/Relationship Cathy L. Williams				A CHILDREN		Oxon Hil			o Code)
1	-	20a. Method of Disposition		20b. Pl	ace of Dispo	esition (Name of matory or other place		Date Date	_•,	20745 ecation - City or Te	own, State
		1 ☐ Burial 2/☐Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control Con		State				/15/2006	Rive	erdale, 1	Maryland
DUCE		21. Signature of Funeral Service Lic	ensee	. `				Freeman Fund			
	+	23a. Part Linter the disease, or co	molications that	caused the death				and, Marylar rdiacorrespiratory a		752	Approximate
n al		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Abdo	each line. minal / Pe	elvic S	errome				1	Onset and Death 3–4 years
r	- 1		Due to	(or as a consequ	ience of):	arodiu					J 4 years
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DHMH 17 Rev 1/2001

Registrar

Weisbrod

06209 State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** February 8 2006 ROSCOE BARNETT WOODRUFF, JR. 7:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2626 Rigging Drive Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 579-52-9021 Yrs. Director March 12 1919 Washington DC 86 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23s or 28s-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Maryland Anne Arundel Annapolis 10f. Zip Code Direct 10g. Citizen of What Country? 10e. Street and Number United States 21401

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 2626 Rigging Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 25 Married 1941-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Colonel U.S. Air Force 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Roscoe Barnett Woodruff, Sr. Alice Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Eilzabeth Dunstan Woodruff, Wife 2626 Rigging Drive, Annapolis, MD 21401 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuriaf 2 ☐ Cremation 3 ☐ Removat from State Arlington Natl Cem. 03-09-2006 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Signature of Michael (1) John M. Taylor Funeral Home Ind 147 Duke of Gloucester Street Annapolis MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) 10 MAMA Physician VP915 /Medical three) Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 Ø No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown this certificete has been signed ral director, pege 2 should be det 23e. Did tobacco use contribute to the cause of death? Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospitaf: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending To the most after death.

Within 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide the Hospitel 29a. Certifier 🎢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 3 2006

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State	of Maryla				lealth a	and Menta		ene	106	062	10
			1. Decedent's Name (First, Middle	e, Last)							e of Death			3. Time of	Death
***	Physici /Medic		Ruth Gordon Was	ley						Feb	ruary	6,	2006	3:30	$P^{M}$
E	Examir	er	4a. Facility Name (If not institution	•					Location of	of Death		4c. Co	ounty of Death		
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			Usual Residence of Decedent		00					pept	- 21,	171	7 Mai	ne	
	anylan show	1	10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside Cit	
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93	el', o		3 ☐ Widowed 4 🎇 Divorced	If Yes G	ive Dates:		1 🗌 Yes	2 <b>∑</b> No	Specify:			Sp	ecity: Wh	nite	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28a-1 ehow La Madical Examiner chas De Lodillied at	Completed	15. Deceden (Specify only higher	t's Education	)	16a. Dece				t of working	16	6b. Kind	of Business/In		
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Ž	12 should be f and Mental H Is marked of reumatic eve	ဥ	19a. Informant's Name/Relations	hip (Type Print)		19b Mailir	ng Addres			or or Rural Route		City or To	own State Zir	Codel	
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ē,	s 1 av		20a. Method of Disposition			Place of Dispo	sition (Na	me of	1	Date			tion - City or To		
Ē	Page nent of nt: If iry or		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		State Bal	timore				/10/2006	Б	alti:	more, N	Marvlan	ıd
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is eny Injury or other tree 2008.		21. Signature of Funeral Service	Licensee		22	2. Name a	nd Addres	s of Facilit	y John M	1. Tay	lor	Funera	al Home	e, Inc
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	See that the death certificate be executed we that the death certificate be executed by the attending physician and perfectly the detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>CAD</u> Due to	diac Ar (or as a conse	quence of):								Onset and D	eath
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Division of Vital Records,	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	of Injury - At hing, etc. (Spec		eet, factor	y, office			ation (Stre or Town,		umber or Rura	il Route Numb	70 <i>r</i> ,
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)			X	Lon	m			D3256	7		*-	21	710	صر	
			30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	Print)					0.00			
	AND DESCRIPTIONS		Dr. Laurie J. P. 31. Date filed (Month, Day, Year)	oss, M.D.	2200 Registrar's Sign	Defens	e Hw	yC	rofte	n, Mary	land.	2111	4		
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			1 - State Registrar		Ce	rtificate of	Death		Reg. Ne.	J b	0621	
	Physici		Decedent's Name (First, Middle, La Florence	Mary	Wa	lters		2. Date of De Month Februa:		2006	3. Time of De 5:30A.	ath M
	/Medio Examin		4a. Facility Name (If not institution, given 4819 Indian Lane	ve street and number)		4b. City, Town, o	r Location of Death		4c. Coun	ty ol Death	eorge's	
	Funeral Director		Social Security Number 6.3	Sex 7. Age ( <i>lin yrs</i> 1 ☐ M <b>※</b> ☐ F 8	. last birthday) 6 Yrs.	If Under 1 Year Months Days	<u> </u>	8. Date of Bin (Month, Da	th ly, Year)	9. Birthp	place (State or Fo	oreign
	0		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	peation		Sept.10	,1919		od. Inside City L	
	he Mary 28a-f eho culled	ector	Maryland Prince (	George's C	ollege						1X Yes 2	
	death with the Maryland me 23a or 28a-f ehow r must be notified at	Funeral Director	10e. Street and Number 4819 Indian Lane			10f. Zip Code 2	0740		10g. Citizen of United			
9500-	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene environment is marked other than "naturel", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinat must be notified at once.	by Fune	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		Was Decedent of H II Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Spec	ace - Americ ack, White, ify: Wh		
7-6171	within 72 handene. Than "natu Than "natu	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	1		pation during most of work d)	king	16b. Kind of			
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	to the pospinel of winebung Frigstrain: The law thin 24 hours after death. To thin Funereli Director: After this certificate has i completely filled in by the funeral director, page 2.9	Certification:	4 Homicide determined	building, etc. (Speci	(fy)			City or Tow	vn, State)		l Route Number,	
	ne nosp in 24 hou he Fune pietely fil	Medicai	29a. Certifier 1 Certifying Pt (Check only one) Medical Exam	hysician: To the best of my knimer: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the ored at the time,	cause(s) and m date and place	nanner as st , and due to	ated. the cause(s)	
,	[O	Σ	29b. Signature and title of certifier	M		29c. Licens D56			29d. Date sign Februa		0ay, Year) , 2006	
			30. Name and address of person who Nasreen Kango, M.	completed cause of death (Ite. D. 7610 Carro	m 23a) (Type, 11 Aver	Print) nue Takom	a Park, M	Maryland	20912			
'n	Sta Registr		31. Date filed (Month, Day, Year)	32/Registrar's Sign		whis)	·					

			1 - For State Registrar	State	of Mary	rland / Dep <i>Ce</i>	artment of <i>rtificate of</i>				Reg. No.	006	062	212
	Physici	an	Decedent's Name (First, Midd		, 1				1	2. Date of De Month	Day	Year		e of Death
	/Medio	cal	Helen  4a. Facility Name (If not institution		lard		45 0% 7			Februa		2006		L:30PM
	Examir	ier	Montgomery Ge				4b. City, Town, Olney		or Death			County of Dea Iontgom		
	Funeral	(	5. Social Security Number	6. Sex	*	yrs. last birthday,	If Under 1 Yea	r If Under 2	24 Hrs.	8. Date of Bir	th			te or Foreign
140	Director		310-20-9791	1□M 2ĀF		84 Yrs.	Months Day	s Hours	Min.	SEPT •	9, 19	21 In	ountry) idiana	te or Foreign
	pu ,		Usual Residence of Decedent  10a, State 10b, County		140	- City Taylor								
	sho	5		gomery		c. City, Town or L Crawford							1	e City Limits es 2 □ No
	28a-f	Director	10e. Street and Number				10f. Zip Code				10a Citia	en of What C		
	with Ba or	ā	1602 East Ur	ion Drive	<b>.</b>			933						Americ
	72 hours after death with the Maryland "naturel", or Itams 23a or 28s-f show idical Examinat must be notified at	Funeral	11. Marital Status	12. Was De	cedent Ever	in U.S. 13.	Was Decedent of If Yes, specify Cu		gin? (Spec			4. Race - Am		
9	after or Ita		1 Never Married 2 Mar	ned 1 Tyes	2 <b>X</b> No		If Yes, specify Cu 1 ☐ Yes 2 ☐XN		i, Puerto R	lican, etc.)		Black, Whi	ite, etc. Thite	
21215-0036	rel',	d by	3 ☐ Widowed 4 ☐ Divorce	Year or	Dates:		1 105 2 AN	о зр <del>о</del> спу:				Specify: W	mile	
7	"natu	Completed		nt's Education est grade completed	)	16a. Dece (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e during most	t of working	g	16b. Kin	d of Business	s/industry	
12	within ene. than "	dmo	Elementary/Secondary (0-12)	College	(1-4or 5+)		Homemake				Over	Home		
9	filed Hyg Sther		17. Father's Name (First, Middle,	Last)			Homemake	1	r's Name	(First, Middle	1			
an		To Be	Lloyd V. Got	t					Marie	e Rite	nour	,		
Maryland	2 should and Men is marke	-	19a. Informant's Name/Relations	, , ,, , ,			ng Address (Stree							
	12 E	1	Trena Ezzati-F	lice - Dau	ighter	2 L	ittle Br	ooke C	ourt,	, 01ne	y, Ma	ryland	20832	2
Baltimore,	8 = = = U		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 DiRemoval from		Ob. Place of Dispo cemetery, cre	osition (Name of matory or other pl		Da		20c. Loc	cation - City or	Town, State	
Ë			4 Donation 5 Other (	Specify)		Rose Hil		-		3/2006		.llsbor		
Bai	permit. Depertr Importe any Inje	E .	21. Signature of Funeral Service	Vicensee			2. Name and Add 1800 New							
8760,	Physician /Medical Examiner	cal Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	o (or as a co o (or as a co o (or as a co	manufacture of the control of the co	tersis pstruc		n 1	Manual Ma		iseosc	Approximination interval I onset at 2 USS	Between nd Death PES
.O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 🗍 nant at time	Fetal death 3	Ectopic pregnan Other (specify)	су			2	3d. Date of de Month	elivery Day	Year
S, D	86 50	by P	Part II. Other significant conditi	ons contributing to	death but no	ot resulting in the u	inderlying cause g	iven in Part I.		23e. Did t	obacco us	se contribute to	o the cause	of death?
ord	w require been si should t									1 🗆	Yes 2	3No 3350	robably 4	Unknown
Vital Records,	The ate h page	Completed								24a. Was auto perfo 1 🗆 Yes		24b. Were a prior to death?		gs available of cause of
Ξ	Physician: 1 this certificaral director, p	o Be	25. Was case referred to medical examiner?  1  Yes	Hospital:	/	0 C F D (O		ther		Check only				
of		<b>-</b>	27. Manner of Death	28a. Date	atient of Injury	2 ER/Outpatie	IL 3L DOX	4 🗆 1901		e 5 Resi		Other (Spe	ecify)	
ion	Attending Ph ir death. ector: After th by the funeral	atio	1 Accident 5 Pending	ng (Mo igation	nth, Day Ye	ar) Injury		ork? ⊒Yes 2 ⊟ N	No					
Division	al or Attend s after death I Director: , d in by the f	Certification:	3 ☐ Surcide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Plac	e of Injury - ding, etc. (S	At home, farm, st (pecify)	reet, factory, office	9	28	3f. Location ( City or To		Number or R	ural Route N	umber,
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	edical C	29a. Certifier 1 Certifyi (Clock onl) 2 Medical	ng Physician: To the Examiner. On the and ma	e best of my basis of exa oner stated.	y knowledge, deat imination and/or in	h occurred at the vestigation, in my	time, date and opinion, deat	d place, ar	nd due to the d at the time,	cause(s) a date and	and manner a place, and due	s stated. e to the caus	θ(s)
	To the within 2 To the complet	Me	29b. Signature and title of dertifie		. 15		1 .	nse number			29d. Date	signed (Mont	th, Day, Year	r)
	20		MW	Mr.	MD		DO	0063	3199	0	21	808	o	
	V		30. ame and a dress of version	who completed car	se of death	(Item 23a) (Typ	Print)	Willia	5.	No.	۷ 	4 , M	N 2	0000
1		9 3	31. Date filed (Month, Day, Year	CANONA	Registrar's S	Signature		MILL	Uni	16 (	Ime	4 , M	D de	1829
3	Sta Registr		FEB 14	2006	September 5	S. So	galle)							

			1 - State of Marylan			of Health a of Death			giene Neg. No.	06	06213
	Physici		Decedent's Name (First, Middle, Last)     Mary A. Weekley					2. Date of Dea Month Februa:	Day	2006	3. Time of Death 8:25A. M
	/Medio		4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital		4b. City, T Laur	own, or Location o	of Death	restad	4c. Co	unty of Deat	
	Funeral Director		5. Social Security Number  230-22-0653  Usual Residence of Decedent	last birthday) 32 Yrs.	If Under 1 Months	Year If Under Days Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May 8,	, Year)	9. Birt Co Vir	hplace (State or Foreign untry) ginia
	Aaryland	or	10a. State 10b. County 10c. City	y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 XNo
	se or 28a-	Funeral Director	10e. Street and Number 12002 Gordon Avenue		10f. Zip (	<sup>20705</sup>				of What Co	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23s or 28s-f show eny liquity or other traumatic event, the Medical Exacili ar minal ke notified at ange.	by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decede If Yes, specif	ent of Hispanic Ori fy Cuban, Mexicar	gin? (Spec	cify Yes or No- lican, etc.)		Race - Ame Black, Whit ecify:	oncan Indian, e, etc. White
Maryland 21215-0036	within 72 hou ene. then "nature he Medice! E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use inting	k done during mos e retired)	t of workin			of Business	Industry  u Investigation
land 2	should be filed ind Menta! Hygi marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Thomas Lee Anderson			18. Mothe		(First, Middle,		mame)	
, Mar	and 2 sho eelth and in 27 le mu		19a. Informant's Nama/Relationship (Type, Print) Lisa Curtis Weekley -daughter			(Street and Numbe edge Roa					
altimore,	Pages 1 annot of He ant: if Item		1X Busial 2 Commetion 2 Demouslifrom State	lace of Dispo emetery, crei ionUnite	matory or oth	e of her place) dist <b>ch.c</b> em		ate 2/13/201			Town, State
Balt	permit. Departingontal		21. Signature of Funeral Service Licensee	Dc 42	2. Name and Onald 400 Po	V. Borgw Wder Mil	årdt 1 Roa	Funera d Belt	l Hom svill	e, PA e, Mar	yland 20705
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Sepsis	rest,		Approximate Interval Between Onset and Death					
No.	Examiner		Due to (or as a conseq Chronic Sequentially list conditions.	Respir	ratory	Failure					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the buriat-transit	al Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence of the cause o	Obstru	uctive	Pulmona	ry Di	sease			
ယ	ertificate ding phys	/Medic	IF FEMALE:								
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	Ideath 3[	□Ectopic pre □ Other (spe				230	. Date of de Month	Day Year
rds, P	w requires that been signed b should be deta	Ď	Part II. Other significant conditions contributing to death but not res Acute Colitis	ulting in the u	inderlying ca	use given in Part I			obacco use		o the cause of death?
Division of Vital Records,	The taw re ate has be page 2 sho	Completed								t4b. Were an prior to death?	utopsy findings available completion of cause of
Vita	Physician: r this certificatal director,	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No  Hospital: 1 \( \text{No} \) Inpatient 2	ER/Outpatie	nt 3□ DO/			<i>(Check only</i> one 5 □ Resid		Other (Spe	icify)
sion of	ing After une		27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation 22.	28b. Time o Injury		Bc. Injury at Work?	2	8d. Describe h			
DİXİ	tal or Attend 's after death el Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury : At h. building, etc. (Specification of the state of the st		reet, factory,	, office	2	8f. Location (S City or Tox		lumber or R	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my known one)  Certifying Physician: To the best of my known one of the best of the best of my known one of the best	wledge, deat ition and/or in	th occurred anvestigation,	at the time, date ar in my opinion, dea	nd place, a ath occurre	and due to the	cause(s) ar date and pl	d manner as	s stated. e to the cause(s)
		M	29b. Signature and title of certifier		1	013687				-	th, Day, Year) 9, 2006
	20		30. Name and address of person who completed cause of death (Iten Joselito Magday, M.D. 11701 Rob	by Aver	nue Be	ltsville	, Mar	yland	20705		
	Sta Regist		31. Date filed (Month, Day, Year) S2Registrar's Signal FEB 14 2006	ture for	ali						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete' Registral Reg. No. UUG Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 23, 2006 2:00 AM M **Physician** Roland Eugene Willard, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Homewood at Crumland Farms If Under 1 Year If Under 24 Hrs. 8. Date of Birth May May 14, 1922 9. Birthplace (State or Foreign Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**♥** M 2□ F 83 220-05-6775 Yrs Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Frederick 1 ☐ Yes X☐ No Maryland Frederick Director 10f, Zip Code 21704 10g. Citizen of What Country? 10e. Street and Number U.S.A. 3012 Thurston Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2X No 1Yes, Give 1 Never Married 2XXMarried ŏ 1 ☐ Yes 2X No White Baltimore, Maryland 21215-0036 Specify Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within. In and Mental Hygiene. 7 ts Æarked other then "r Elementary/Secondary (0-12) 12 College (1-4or 5+) US Government Engineering Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pearl Eleanor O'Hara John Lee Willard 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3012 Thurston Road, Frederick, Maryland 21704 Mrs. Mary Louise Willard, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Pleasant Hill Cemetery Feb. 27, 2006 Monrovia, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 MOO255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Known to physician as Roland Willand Division of Vital Roman of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an 2 No 1 Yes Director: After this certific in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2-23-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, M.D., 4 Culwell Drive, Mt. Airy, Maryland 21771

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) WAR 0 1 2006

OD JOB M

2. Registrar's Signature

			State of Maryland / Dep  State of Maryland / Dep  Registrer Ce	artment of Health and I rtificate of Death	Mental Hygie Reg.	ZHUb UbZlo		
	Physici	an	Decedent's Name (First, Middle, Last)     Louise A. Yocum		2. Date of Death Month	Day Year 10, 2006 11:04A. M		
	/Medio	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	February	4c. County of Death		
			Holy Cross Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Silver Spring  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgomery		
	Funeral Director		578-22-4325 1 M 2XF 82 Yrs.	Months Days Hours Min.	Oct. 10, 19	9. Birthplace (State or Foreign Country) Kentucky		
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation	-	10d. Inside City Limits		
	e Mary	ctor	Maryland Montgomery Silver	Spring		1 ☐ Yes 2X No		
	deeth with the Maryland ims 23a or 28a-f ehow r must be notified at	i Dire	10e. Street and Number 3128 Gracefield Road, #403	10f. Zip Code 20904		Citizen of What Country? Jnited States		
		Funeral Director	Armed Forces?	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.		
350	hours after tural', or its	þ	1 Never Married Married 1 Yes, Give Year or Dates:	1 ☐ Yes 2 【XNo Specify:		Specify: White		
21215-003b	nin 72 h in "natu Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+)	dent's Usual Occupation skind of work done during most of wor DO NOT use retired)	king 16t	o. Kind of Business/Industry		
	filed within 72 Hygiene. other then "nate ent, the Medic	Com	12 Home	maker	ne (First, Middle, Mai	own home		
yland	ild be fi Sental H rked ott ilc ever	To Be	17. Father's Name (First, Middle, Last)  James B. Barnes		Sigmond	den Surname)		
Mary	2 should and Men ie marke raumatic	-				ity or Town, State, Zip Code) 20904 er Spring, Maryland		
	s 1 and f Health item 27 gther tr		20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place)		c. Location - City or Town, State		
Baitimore,	Peges ment of ant: If it		4 Donation 5 Other (Specify) Fort Lir	coln Cemetery 2/1		entwood, Maryland		
Pail	permit. Pages 1 and 2 should b Deperment of Health and Menta important: if item 27 is marked eny injury or other traumatic ance.		21. Signature : Turkral Since License	onald V. Borgward 400 Powder Mill R	t Funeral oad Beltsv	Home, PA ville, Maryland 20705		
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hear failure. List only one cause on each line.		or respiratory arrest,	Unset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute Myocardia Due to (or as a consequence of):	1 Infarction		4 hours		
	Examiner	-	Sequentially list conditions, The resulting to immediate by Due to for as a consequence of).					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.					
8/60,	ie be executed /sicien and e burial-transit	ai Ex	resulting in death) Last  Due to (or as a consequence of):					
9	rtificate ng physi as the	Medicai	IF FEMALE:					
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
J.	at the de I by the a steched	Physi	9 ☐ Unknown					
	w requires that been signed to should be dete	र्व	Part II. Other significant conditions contributing to death but not resulting in the Hypertension	underlying cause given in Part I.	1 ☐ Yes	co use contribute to the cause of death?  2 No 3 Probably 4 Xunknown		
ecol	law req as beer 2 shou	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
a E	ician: The law certificete has rector, page 2 (				performed 1 ☐ Yes 2 ☐			
5	Physician: this certific al director.	To Be	25. Was case referred to medical examiner?  1 Xes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	TT Other	ome 5 Residence	e 6 Other (Specify)		
o uo	iding Ph th. : After th funeral		27. Manner of Death 1 ZNatural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred		
Division of Vital Records,	or Attendi efter death. Director: A in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	ot and Number or Rural Roule Number, State)		
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funerei Director: After this certifica	Medicai Co	29a. Certifier (Check out) one)  12 Certifying Physicien: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or in	th occurred at the time, date and place envestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		
	To the within ?	Mec	29b. Signature and title of certifier	29c. License number D23649	29d.	Date signed (Month, Day, Year) February 10, 2006		
,	10		30. Name and address of person who completed cause a death (Item 23a) (Type					
			John Stuckey, M.D. 3110 (Gracefield F		, Maryland	1 20904		
	Sta Registi		31. Date filed (Month, Day, Year)  FEB 1 4 2006  32. Registrar's Signature	rede				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 10e per 1h 9853 3-2-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Hanes 9:00 AM ORRAINE February 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimoro TOWSON Jilchrist Center 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MANY Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F Months Days Hours Min 67 219-26-2430 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits in then "natural", or Items 23s or 28s-f show 1 ☐ Yes 2 No Maryland Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2943 Northwind Rd 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2121 permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then 'eny Injury or other traumatic event, tra Meganda. College (1-4or 5+) Elementary/Secondary (0-12) ffice Injured weaters Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) ROSE William A. Kathleen Kintsler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 2943 Northwind Road Bullimore MD 21234 Agnes Francis imore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Sykesville Maryland 1 Burial 2 □ Cremation 3 □ Removal from State A Keview me merial PAIK March 4-2006 4 ☐ Donation 5 ☐ Other (Specify) evans Funeral Chapel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latura an Blactuto 8800 Harford R& Bultimore maryland 21234 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reasT CANCER **Physician** cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attanding physicien and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) sete hes been signed by the page 2 should be detached Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete 2 | No 1 Yes 2 No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours efter death.

To the Funerel Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Division Attending Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number uno who completed cause of seath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

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State of Maryland / Department of Health and Mental Hygiene

/Medi	ian cal	Decedent's Name (First, Mid	idie, Last)	Els	se apF	Rhys				2. Date of Dea Month Febru	Day Uary 28	Year , 2006	3. Time of Dea
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uneral irector		5. Social Security Number 212.60.1295	6. Sex 1 □	M 2√F		30 Yrs.	Months Day		Min.	(Month, Day	, Year)	Dut	thplace (State or For H <sup>nt</sup> <b>East In</b> Helland
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ns 23	era	2890 Bethany Lan		2. Was Dece	edent Ever in	U.S. 13.	Was Decedent of			cify Yes or No-	14.	Race - Ame	erican Indian,
"natural", or items 23a or 28a-f show Idical Examiner must be notified at	Funerai	1 ☐ Never Married 2 ☐ M		Armed For	rces? 2 No		Was Decedent of		, Puerto	Rican, etc.)		Black, Whit	te, etc.
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Physicia		1. Decedent's Name (First, Middle, Last)  Joseph S. Brennan	l			2. Date of Death Month FEBRUARY	<sup>D</sup> 26, 2006	3. Time of Death
/Medica Examine	_	4a. Facility Name (If not institution, give street and number Saint Joseph Medica	er)		r Location of Death TOWS		4c. County of Deat	timore
Funeral Director		5. Social Security Number 6. Sex 7. 1\frac{1}{1}\frac{1}\frac{1}\frac{1}\frac{1}{1}\frac{1}\frac{1}\frac{1}{1}\frac{1}\fr	Age (In yrs. last birth	nday) II Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV 23	9. Birt 922 N	hplace (State or Foreign untry) aryland
Aaryland I show	ō	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Town	or Location Baltimore	_			10d. Inside City Limits 1 X Yes 2 ☐ No
with the A	Funeral Director	10e. Street and Number 108 W. Saratoga Street		10f. Zip Code 212	201	10	g. Citizen of What Co	untry?
a 0 =	کر ا	11. Marital Status  12. Was Decede Armed Force Armed F	s? No	13. Was Decedent of H If Yes, specify Cuba 1 Yes XX No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
permit. Pages 1 end 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "naturel, any injury or other treumatic event, Item Medical Exa once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)	or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Doorman	ation during most of worki d)		Engineer's	,
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Pri pri	cai Examiner	resulting in death)  Due to (or C RO  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or C RO)	Tine.  EMYDCAF as a consequence of	RDIAL INFA n: FERY DISEA n:	ARCTION	or respiratory arres	it,	Approximate Interval Between Onset and Death ONE DAY
To the Hospital or Attending Physician: The law requires that the death certiticate Ewithin 24 hours effer death.  Within 24 hours effer death.  To the Funeral Director: Atter this certificate has been signed by the ettending physic completely filled in by the funeral director, page 2 should be detached for use as the beauties of the funeral director.	Physician/Medic		2 Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify) □	′		23d. Date of dei Month	ivery Day Year
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Physicia this cert al direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inp	atient 2 ER/Outp	patient 3 DOA	00		ce 6 Other (Spe	cify)
To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: Atter this certificate hi completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	Day Year) In	jury Wor	Yes 2 □No	28d. Describe hov  28l. Location (Stre City or Town,	et and Number or Ri	aral Route Number,
lospital or hours eft uners! Di	edical Cer	29a. Certifier (Check only 2   Medical Examiner: On the basi	est of my knowledge,	death occurred at the tie	me, date and place,	and due to the cau	use(s) and manner as	stated.
To the h within 24 To the F complete	Medi	29b. Signature and title of certifier	stated.	29c. Licens		29	d. Date signed (Mont	h, Day, Year)
5		30. Name and address of person who completed cause of			017695	re	bruary .	20,2006
Stat		31. Date filed (Month, Day, Year) 32. Bog	istrar's Signature	01 OSLER I	DRIVE, T	OWSON.	MARYLANI	21204
Registra	al .	0 % 2000	same Se	South .				

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06 - 1451Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S Unpend item # 23a State of Maryland / Department of Health and Mental Hygiene ROBERT BOLDEN Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 0710 A M Montgomery Robert Bolden FEB2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 820 SOUTH CATON AVENUE APT. 2-N Examiner BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F 56 Director 217-52-8514 Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or Iteme 23a or 28e-f ehow the Medical Examinar must be notified at XXYes 2□No Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 death v 3722 Woodbine Ave U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer na Various Jobs 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked than any injury or other traumatic evonce. Harry J. Bolden Sr. Elenora L. Bayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hilda Parker-Sister 3806 Copley Rd, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3/4/06 Randallstown, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Hospitel or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 L Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1XXYes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) AT SCENE٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending after death.

I Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ within 24 hours after To the Funerel Direct 4 | Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

O.C.M.E

111 PENN STREET, BALTIMORE, MARYLAND 21201

FEB.

27, 2006

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

miD

32. Registrar's Signature

**ORIGINAL** 

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31. Date filed (Month, Day, Year)

			For State Registrar	State	of Maryla		artment of H rtificate of I	lealth and M Death		jiene )	Common Co	06221
	Physicia	20	1. Decedent's Name (First, Middle, La						2. Date of Dea Month		Year	3. Time of Death
	/Medic	al	Dorothy A. Beiner						Februar			11:05 A M
	Examin	er	4a. Facility Name (If not institution, giv Collingswood Nurs				4b. City, Town, or Rocky	Location of Death			unty of Death ontgome	. <b>2</b> 37
			5. Social Security Number 6. S			rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			lace (State or Foreign try)
	Funeral Director			I □ M 2 🖾 F	79	Yrs.	Months Days	Hours Min.	(Month, Day August	, <i>Year)</i> 19 <b>.</b> 192	26 Penns	ry) Sylvania
			Usual Residence of Decedent		1							
	arylar ahow	_	10a. State 10b. County		10c.	City, Town or Lo					10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he Mi	ecto	Maryland Montgon	nery		Rock	10f. Zip Code			Og Citizon	of What Coun	
	a or 2	Ö	299 Hurley Avenue	2			20850		'		ted Sta	•
	ns 23	era	11. Marital Status	12, Was Dec	cedent Ever in	n U.S.   13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		Race - Americ	an Indian,
Maryland 21215-0036	urs after o	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed F 1 Tes If Yes, G Year or	2 🔼 No iive		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specity:	Hican, etc.)	Sp	Black, White, e ecify: Wh	<sup>etc.</sup> ite
Õ	72 hou	Completed	15. Decedent's E (Specify only highest gra		1	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind	of Business/Ind	lustry
2	ithin 7	nple	Elementary/Secondary (0-12)		(1-4or 5+)	`life.	DO NOT use retired	d)	9	O T		
7	led will ygjer har th	Co	12			Homei	naker	18. Mother's Name	Eirot Middle	Own I		
and	htal H ed otl	Be	17. Father's Name (First, Middle, Last Harry Williams	)				Lola Re	·	Maluell Sul	mame)	
Ž	d Mer mark matic	우	19a. Informant's Name/Relationship (	Type Print)		19b. Maili	ng Address (Street)	and Number or Run		r. City or To	own, State, Zip	Code)
Ma	nd 2 s lth an 27 is trau		Claudia A. Barnet		aughte	1.		Street, G				
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Itams 23a or 28a-1 ahow any injury or other traumatic avant. The Medical Examinar must be notified at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specia		State A	b. Place of Disportery, cre rlington			Date 17,	20c. Locati	ion - City or To	
Baltir	permit. F Departme Importar any injur		21. Signature of Funeral Service Lice			emetery Ro	2. Name and Addres		ert A. T	Pumph:	rey Fun ery Ave	eral Home/
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the d	eath. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arr	est,	-	Approximate Interval Between
	Pnysician	e 10	Immediate Cause (Final disease or condition		psis							Onset and Death
	/Medical		resulting in death)	_ d		sequence of):			777			
	Examiner		Sequentially list conditions,				: Failure					
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9	tificat ig phy as the	led										
.O. Box	that the death certific ted by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown		birth 2 DF nant at time	etal death 3	□Ectopic pregnancy □ Other (specify)	/		23d	. Date of delive Month	ny Day Year
σ.	res that t igned by be deta	y Ph	Part II. Other significant conditions	contributing to	death but not	resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
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Records	taw requires as been sign 2 should be	Completed							24a. Was a		4b. Were autop	osy findings available inpletion of cause of
æ	0 4 0	ШО							autops perfor	med? 2⊠No	death?	
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of Deat				
of V	dis Ys	10	1 ☐ Yes 2 🔀 No	Hospital: 1	Inpatient :	2 ER/Outpatie		4 KJ Nuising No	me 5 🗆 Resid			)
	ding P	on:	27, Manner of Death 1    Natural 5 □ Pending	(Mo	e of Injury nth, Day Yea	r) 28b. Time of Injury	Wor	k?	28d. Describe h	ow injury o	ccurred	
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	To the Hospital or Attanding Phylibin 24 hours after death. To the Funaral Director: After the Completely filled in by the funeral	edical C		miner: On the				ne, date and place, ppinion, death occur				
	Vithin To the Mithin Yompil	Me	29b. Signature and title of certifier				29c. Licens	e number	2	29d. Date s	igned (Month, I	Day, Year)
			thorn	M	·Di		D301	.32		Febru	ary 23,	2006
	D		30. Name and addless of person who									
	,		M. Rita Chosh M.D				Lane, #221	l, Rockvi	lle, Mar	yland	20850	
•	Sta		31. Date filed (Month, Pay, Year)	2006   32.	Registrar's S	ignature	Joseph					
	Registi	all			460 (35 D)-	19						

2. Date of Death

perilliore, Marylaring A.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	Fu	e fortified a comment
important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow	เม	
ony injury or other traumatic event, the Medical Examinar must be notified at	er	
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	Funeral Director		5. Social Security Number 6. Se 288–16–0925	7. Age	(In yrs. last t	birthday) Yrs.	If Under 1 Y Months D	ear If Un ays Hou	der 24 Hrs. rs Min.	8. Date of B (Month, D Sept.	irth av Yea 15,	1922 C	Birthpla Countr )hio	ace (State or Foreign y)
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10	d. Inside City Limits
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	with a or	늅	9707 Old Georgetow	m Road				20814				ited St		•
	eath	erai		12. Was Decedent E	ver in U.S.	13. \			Origin? (Sp	ecify Yes or N		14. Race - /		
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or Items 23a or 28a-f show event, Ite Medical Examerational to notified.	Completed	15. Decedent's Edu (Specify only highest grad	cation	16	a. Deced	lent's Usual O	ccupation	most of work	ina	16b	. Kind of Busin	ess/Indi	ustry
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e)	s 1 and 2 should f Health and Men frem 27 is marke other traumatic		Barbara Norris/Dau 20a. Method of Disposition	ignter			sition (Name o			Date		. Location - City		
Baltimore,			1 ☐ Burial 2 🛣 Cremation 3 ☐ F		Montg	omer	natory or other Y	r place)	Marc	h 1,				
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			shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	θ.			, 3.		. ,				Interval Between Onset and Death
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39	ntifica ng pt	Med	IF FEMALE:										-	
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0.	the deg y the a	sic	1 ☐ Yes 2 X No 9 ☐ Unknown	4□ Pregnant at t 9□ Unknown	time of death	5	Other (specif	ý)						, , , , ,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune			sician: To the best o										
	To the H within 24 To the F complete	Medical	one)  29b. Signature and title of certifier	and manner stat				cense numb		1		Date signed (A		
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State

Registrar

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2. Registrar's Signature

			For State Registrar	State of Ma		/ Depa	artme		ealth ar		ntal Hyg		000	e.	16223
\$ <sup>8</sup>	Physici		1. Decedent's Name (First, Middle, Last) BETTY				ST			1	Date of Dea Month	ath Da	v Y	ear 06	3. Time of Death
	/Medio Examir	er	4a. Facility Name (If not institution, give : JOHNS HOPKIN S BAYVIE		CE	UTER	-	y, Town, or ALTIN	Location of I	Death			. County of		
*.	Funeral Director		210 00 0001	M 2DF	(In yrs. ia	st birthday) Yrs.	If Und Months	er 1 Year s Days	If Under 24 Hours	Min.	Date of Birt (Month, Day MAY 1,	y, Year)	40	. Birthp Coun	lace (State or Foreign htry)  MD.
	Maryland f show	or	Usual Residence of Decedent	'E	10c. City,	Town or Lo	cation GEMI	ERE						1	0d. Inside City Limits 1 ☐ Yes 2 ☆No
	a with the	Funeral Director	10e. Street and Number 7207 BUCHER RD.					Zip Code	19			-	tizen of Wh		•
036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic svent, the Modical Examinar must be notified at Once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give X Year or Dates:				edent of H ecify Cuba 2 X No	ispanic Origin, Mexican, I	n? (Specif Puerto Ric	y Yes or No- can, etc.)	-	14. Race - Black, Specify:	White,	
Maryland 21215-0036	s within 72 ho plene. r than "natur the Medical I	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12) 12TH	cation e completed) College (1-4or 5-	+)	life.	kind of v DO NOT	sual Occup vork done d use retired	during most o	of working			ind of Busin		dustry
yland	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) FRANK NOLAN	<u> </u>							First, Middle, STEFFA		Sumame)		
, Mar	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Ty KAREN GAYDOS/DAUG		act Di		LOI	OGE FO			-	EME	RE, MA	RYL	AND 21219
Baltimore,	thent of H thent of H tant: If its		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)		Ce	RO CR	natory of EMAT	ORY	3	3/2/0	6	ВА		RE,	MARYLAND
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	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	MYOCAR	o. DIAL	INFI			g, 30011 d3 00	ardiac or r	espiratory ar	1031,			Interval Between Onset and Death 3 TOURS
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760,	eath certificate be executed attending physician and for use as the burial-fransif	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ence of);									
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	w requires that the state of th	Ď	Part II. Other significant conditions con	ntributing to death bu	it not resul	lting in the u	nderlying	g cause giv	en in Part I.			obacco Yes 2			ne cause of death?
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Division	를 다 하는	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.			eet, faci	ory, office		28	f. Location (S City or Tov	Street a. vn, Stat	nd Number e)	or Rura	Al Route Number,
	ha Hospital in 24 hours in he Funeral pletely filled	ledical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best on ner: On the basis of and manner sta	examinati	viedge, deat ion and/or in	h occurre vestigati	ed at the tir on, in my o	ne, date and pinion, death	place, and occurred	d due to the at the time,	cause(s date an	d place, and	er as si	ated. the cause(s)
)	With To t	Σ	29b. Signature and title of certifier	- SAYU	ηA ι	MD	2	9c. Licens LES	e number				unry (		
	7		30. Name and address of person who co	ompleted cause of de	eath (Item	23a) (Type,	ENU	E , 8	ALTIM	102E	, mar	CYLF	HUD	212	24
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 0 2 200	2. Registra	r's Signat	ure	J.								

	-	State of Man		artment of F		ind M		jiene eg. No.	06	062	24
	e Mg Se M	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year		
Physicia /Medic	al .	CLIFTON B. BALL				( = 1)	MARCH	(	2006		Vr w
Examin	er	4a. Facility Name (If not institution, give street and number)  SINAL HOSPITAL OF RALIZMON	E	4b. City, Town, o			,	46. 0	unty of Death N/A  9. Birthplace (State or Fore MARYLAND)  10d. Inside City Lim 12 Yes 2 1  n of What Country? A  Race - American Indian, Black, White, etc. secify: BLACK of Business/Industry  UCATION  mame)  own, State, Zip Code) RYLAND 21215  tion - City or Town, State  MORE, MARYLAND AL HOME, F.A.  RE, MARYLAND 21  Approximate Interval Between Onset and Death 5 YEARS  10 YEARS  10 YEARS  10 YEARS  10 YEARS  11 ONE OF TOWN YEAR  12 ONE OF TOWN YEAR  13 ONE OF TOWN YEAR  14 ONE OF TOWN YEAR  15 ONE OF TOWN YEAR  16 ONE OF TOWN YEAR  17 ONE OF TOWN YEAR  18 ONE OF TOWN YEAR  19 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  11 ONE OF TOWN YEAR  12 ONE OF TOWN YEAR  13 ONE OF TOWN YEAR  14 ONE OF TOWN YEAR  15 ONE OF TOWN YEAR  16 ONE OF TOWN YEAR  17 ONE OF TOWN YEAR  18 ONE OF TOWN YEAR  19 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  11 ONE OF TOWN YEAR  12 ONE OF TOWN YEAR  13 ONE OF TOWN YEAR  14 ONE OF TOWN YEAR  15 ONE OF TOWN YEAR  16 ONE OF TOWN YEAR  17 ONE OF TOWN YEAR  18 ONE OF TOWN YEAR  19 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  11 ONE OF TOWN YEAR  12 ONE OF TOWN YEAR  13 ONE OF TOWN YEAR  14 ONE OF TOWN YEAR  15 ONE OF TOWN YEAR  16 ONE OF TOWN YEAR  17 ONE OF TOWN YEAR  18 ONE OF TOWN YEAR  19 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  11 ONE OF TOWN YEAR  12 ONE OF TOWN YEAR  13 ONE OF TOWN YEAR  14 ONE OF TOWN YEAR  15 ONE OF TOWN YEAR  16 ONE OF TOWN YEAR  17 ONE OF TOWN YEAR  18 ONE OF TOWN YEAR  18 ONE OF TOWN YEAR  19 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN YEAR  10 ONE OF TOWN		
Funeral		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday)	If Under 1 Year	If Under 2	,	8. Date of Birth	Year)	9. Birti	hplace (State o	or Foreign
Director		213-32-1753 <sup>1</sup> \mathbb{\text{\text{\$\exitt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exitt{\$\text{\$\exitt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exittit{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\}\$}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}	69 Yrs.	Months Days	Hours	Min.	10-17	-1936	5 MA	RYLAND	
and *		Usuel Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Lo	ocation						10d. Inside C	ity Limits
Maryid f sho	ō	MD. N/A	BALTIMO	RE						1 ₹ Yes	2 🗆 No
r 28a-	rect	10e. Street and Number		10f. Zip Code			,	10g. Citize	on of What Co	ountry?	
Mental Hygiene. Mental Hygiene. arked other than "naturel", or Items 23s or 28s-f show aftic event, the Medical Examiner must be notified at	Funeral Director	3914 FERNHILL AVE.		2121				US			
tems	nner	11. Marital Status  12. Was Decedent Even Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Oriç an, Mexican	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)		Black, White	e, etc.	
irs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X If Yes, Give X Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			S	Specify: BI	LACK	
72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	oation during most	t of worki	ng	16b. Kind	of Business/	Industry	
ithin 7 ne. "ren"r	nple	Elementary/Secondary (0-12) College (1-4or 5+) -126-	1	kind of work done DO NOT use retire INISTRATO				द्रा	NIICATT(	)NI	
Hygier ther th		17. Father's Name (First, Middle, Last)	ADM.	INISIRAIC		er's Name	(First, Middle,			<b>714</b>	
d be f ental l ked ol	To Be	JOHN BALL					HAILST				
permit. Pages 1 and 2 should be filad within 72 hours after death with tha Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or items 23s or 28a-f show sny injury or other traumatic svent, the Medical Examiner must be multiled at once.	-	19a. Informant's Name/Relationship (Type, Print) MARY BALL (WIFE)	19b. Maili 39	ng Address (Street	and Numbe	er or Rura E • B.	/ Route Numbe	r, City or E, MA	Town, State, 2 ARYLANI	Zip Code) D 21215	
s 1 an of Heal item 2		Zoa. Method of Disposition		matory or other pla			ate	20c. Loca	ation - City or	Town, State	
Page nent c ant: if		1X Burial 2 ☐ Ofemation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ARBUTUS 1	MEMORIAL	PARK	3-7-	2006				
permit. Departr Imports sny inju		21. Signature of Entral Service Licensee JONATHAN	Bue	1721–27	N. MO	NROE	ST. BA	LTIMO	ORE, MA	ARYLAND	212
Pnysician		23a. Part. Enter the disease, or complications that caused the shock, or lear failure. List only one cause on each line. Immediate Cause (Final disease or condition	e death. Do not en		ng, such as	cardiac d	r respiratory an	rest,		Interval Be Onset and	tween Death
/Medical Examiner		0.45	consequence of):  vellulum toonsequence of):	we I						10 4	EARS
pe lisi	Examiner	cause Enter Underlying	consequence of):	77						5 Y	EARS
be axacuted ician and burial-transit	Exan	that initiated events c.  resulting in death) Last  Due to (or as a continuous)	consequence of):								
cate be physician	edical	d. Atrial	fibriblation							6 m	onth;
he death certiticate be axacuted the attanding physician and chad for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. ff yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey (General			23			Year
w requires that the de been signed by the should be detachad	by Ph	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause g	ven in Part I		23e. Did to	obacco us	e contribute to	o the cause of	death?
quire; an sign	ed b	Coronary witing disease					1 🗆 1	res 2	KNo 3□P	robably 4 🗆	Unknown
sician: The law requires that the certificate has been signed by th irector, page 2 should be detacha	Completed	Congertise heave failure.					24a. Was autop perfo 1 Yes	rmed?	24b. Were a prior to death?	utopsy findings completion of	available cause of
	(a)	25. Was case referred to medical		******			Check only o	ne)			
> 0 0	ToB	examiner? 1   Yes 2   No   Hospital: 1   Inpetient					me 5 Resid			ecify)	
Attending Physician: if death. ector: After this certific by the funaral director.	00:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day)	Year) 28b. Time (	Wo	ıryat ork? ∃Yes 2 🔲		28d. Describe h	now injury	occurred		
daath daath stor: /	cat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of them	/ - At home, farm, s			140	28f. Location (S		Number or A	lural Route Nur	nber,
after after Direct	Certification:	4 Homicide determined building, etc.	(Specify)				City or Tov				
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complataly filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of earl manner state and manner state	xamination and/or i	ath occurred at the nvestigation, in my	time, date ar opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(	s)
Fo the within Fo the comple	Me	29b. Signature and title of certifier		29c. Licer	ise number			29d. Date	signed (Mon	th, Day, Year)	
. > - 0		John July mo		RE	5-129	14		era	rch 1,	Zwil	
15		30. Name and address of person who completed cause of deal LURF Y. WANG, MD STAR.	11.0017.744	OF BALT	ILMORE						
	ate	31. Date filed (Month, Day, Year) 32. Registrar  MAR 0 2 2006	's Signature	Sant a							
Regist	trar	MAR 0 2 2006	V 15 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 2 29d per/doc 8853 3-17-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death **27** 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1=45 PM Chavious Lottie 02 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore
If Under 1 Year If Under 24 Hrs. Samaritan Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F Hours Min 216-32-940/ Usual Residence of Decedent Yrs. Director Irginia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 timore 1 Yes 2 □ No Completed by Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 6000 or Items 23a 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (0-12) if Health and Mental Hygiene. College (1-4or 5+) eaver bore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 117C 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bulle ND 21239 20c. Location - City or Town, State 205. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition Department of H Important: If ite any injury or ot once. 1 ¥Burial 2 ☐ Cremation 3 ☐ Removal from State 13/06 Ra King Memoria 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Wileve Teneral Services Eur W. such as cardiac or respiratory arrest, Apr Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ventricular Fibrillation Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□ Live birth 2 □ Fetal death
4□ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has le 2 1 Yes 2 No 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D RZS-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stol Loch Raven Boulesand & Boulet 1 Buttimore, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 2 2006 Registrar

			1 - For State Registrer	State of Maryla	and / Depa <i>Cei</i>	artment of H rtificate of	Health and Death		giene 0 0 (	6 06226
I	Physici	an	1. Decedent's Name (First, Middle, Last)		Ce	mbrock	Junior	2. Date of Dea Month	Day Y	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)			or Location of Dea		4c. County of	
	LAGITHI		Johns Hopkins Bayusew	Medical Cent	ler	Baltin	nore Cit	y		imore City
E	Funeral Director		5. Social Security Number 6. Sex 189-03-7117	7. Age (In y	rs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		6-1917	Birthplace (State or Foreign Country) Pennsylvania
	pu s		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	nation				10d Jacida Cib. Limita
	e Maryla 3a-f shor	ctor	Maryland		altimore					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	Funeral Director	10e. Street and Number 415 Joplin Street			10f. Zip Code 21224		,	10g. Citizen ol Wh U.S.A	at Country? •
920	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f show apprintury or other traumatic event, the Medical Examinar must be notified at appear.	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I II Yes, specify Cub 1 ☐ Yes 2 📆 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White
20	72 hou	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occu kind of work done	pation	orkin a	16b. Kind of Busi	ness/Industry
2121	d within giene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Wel	DO NOT use retire	d)	nnig	Truckin	g Company
Maryland 21215-0036	uld be file Aental Hy rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Anthony Cembrock					me (First, Middle, ne Gushe		
Mary	alth and N		19a. Informant's Name/Relationship (Ty Rose Cembrock/Wil	pe, Print) É e	19b. Maili 415	ng Address <i>(Street</i> Joplin St	and Number or R	urai Route Numbe More, MD	r, City or Town, St 21224	ate, Zip Code)
altimore,	Pages 1 e ent of Hei nt: if item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		osition (Name of matory or other pla n Cemeter		Date -27-06	20c. Location - Ci	•
Balti	permit. I Departm importar any injur		21. Signature of Funeral Service License	5		2. Name and Addre		Charles Baltimo		r & Son, Inc.
			23a. Part1. Enter the disease, or combine shock, or heart failure. List only or Immediate Cause (Final		eath. Do not en	ter the mode of dyi	ng, such as cardia	ac or respiratory arr		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a cons		+ fairlure	exacert	sation.		20 days
V	uted d ansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a con-	requence of):					
8760,	death certificate be executed e attending physicien and ind for use as the buriat-transit	dlcai Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
9	Jeath certificat attending phy I for use as the	/Medi	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pre	gnancy				23d. Date	ol delivery
.O. Box	thet the death ed by the atter detached for u	Physician/Me	in the past 12 months?  1 □Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	у		Month	
Ω.	8 5 B	þ	Part II. Other significant conditions con		resulting in the u	nderlying cause gr	ven in Part I.		/	ute to the cause of death?
Vital Records,	elaw hasb	Completed	chronic ren	al insufficien	ncy				med3/ de	ore autopsy findings available or to completion of cause of ath?
tal	ician: Th certificete rector, pag	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only or		]Yes 2□ No
Ϋ́	\$ 20 B	To B	examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	2 ☐ ER/Outpatie	nt 3 DOA	hor	Home 5 ☐ Resid		(Specify)
ion of	ding P. After fune		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Wo			ow injury occurred	
Division	Pospitei or Attend 24 hours efter death Funerei Director: stely filled in by the i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	at home, larm, st ecify)	reet, lactory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospitel or Attenwithin 24 hours efter deati To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my nar: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occ	e, and due to the durred at the time, of	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title ol certifier			29c. Licen			29d. Date signed (	(Month, Day, Year)
	ıD		John Should			RES.	000		February	23, 2006
	ال		30. Name and address of person who could have thought in a Hospital	1. Tover 110, E	Pockos L		North L	Volfe St.	Baltimon	e, MD 21287
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	sale)				

			For State Registrar	State o	f Maryland		artment <i>rtificate</i>		ealth and M Death		iene) (	5 (	06227
		S.	1. Decedent's Name (First, Middle, La	st)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Angel	a M. I	rechsl	er				March 1		1 041	2:42 A <sup>M</sup>
1	Examir		4a. Facility Name (If not institution, giv				, ,		Location of Death		4c. County	of Death	
	٤ أ		Genesis Elderca				R		allstown If Under 24 Hrs.	T		alti	
	Funeral Director		5. Social Security Number 6. S 215-78-5309	В м 2 ДУF	7. Age (In yrs. la			Days	Hours Min.	8. Date of Birth (Month, Day,	Year)		place (State or Foreign
			Usual Residence of Decedent			- /				NOV 8,	1936	Mar	yland
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	e Maria-f	ctor	Maryland Balt:	imore				Rar	ndallstow	m			1 ☐ Yes 2 ☐XNo
	ith th	Director	10e. Street and Number				10f. Zip (	ode		1	0g. Citizen of V	Vhat Cou	intry?
	ath w 23a		9 Cassandra Co					4	21133			USA	
	within 72 hours after death with the Maryland jiene. rithen "naturel", or items 23a or 28a-f ehow the Madical Examiner must be motified at	Funerai	11. Marital Status  1 X Never Married 2 Married	12. Was Deci		S. 13.	Was Decede If Yes, specif	nt of His y Cubar	spanic Origin? (Sp. n. Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Amen k, White	can Indian, , etc.
336	urs af	b	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve		1 ☐ Yes 2	X No	Specify:		Specify	· W	hite
9	72 hor	ted	15. Decedent's E			16a. Dece	dent's Usual	Occupa	ition		16b. Kind of Bu		
21215-0036	within 7 ene. than "r	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (	1-4or 5+)	_			uring most of work	mg			
	il Hygien other th	Cor		2		Ca	ase Ma	nage				1the	are
Maryland	be fill	Be	17. Father's Name (First, Middle, Last,		e Cee				18. Mother's Name				
ž	2 should t and Ment is marked	T <sub>o</sub>	John Joseph Di		., 51.	19h Mailir	an Address	Street a	nd Number or Run	tte Anne			n Code)
Ma	d 2 s ith an 27 ts i				/Mahlass		assand			ndallsto	92.0	naerani	
ē,	s 1 end 2 should be filed f Heelth and Mental Hyg item 27 is marked othe other traumatic event,		Charlotte A. Dre 20a. Method of Disposition	•	20b. Pt	lace of Dispo	sition (Name	of of			20c. Location -		
9	Pages nent of int: If it iry or o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		State				nc. 3/2/	'06	Ralt	imor	e. MD
Baltimore,	permit. Pages Department of Important: If i eny injury or one		21. Signature of Funeral Service Lice	nsee //	/ 5	22	2. Name and	Addres	s of Facility Cr	emation	Societ	y of	MD, Inc.
<u>m</u>	88 = 58		Edward A. C	regorchi	ik				cick Road				
*			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on e	caused the death each line.	. Do not ent	er the mode	of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a.	(or as a consequ	200	2014	5	1 Paile	nre			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ					-2 1			
2		- G	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ		XIC		neepho	राकिका	try		
V	icate be executed physicien and s the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events			S	ept	10	erma				
v O	exec an and rial-tra		resulting in death) Last	Due to	(or as a consequ								
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9	ng pt	Med	IF FEMALE:								1		
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		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ⊟Pregr 9⊟ Unkn	nant at time of de own	eath 5L	Other (spe	cify)					,
P.O.	£ 26 €		Part II. Other significant conditions (	contributing to d	eath but not resu	ilting in the u	nderlying ca	nse dive	n in Part I.	23e. Did tol	pacco use cont	ribute to t	the cause of death?
ds	uires n sign	d by		0000	ho-PI	nlmor	794	0	irrest	1 🗆 Ye	s 2 🗆 No	3 ☐ Pro	bably 4 🗀 Unknown
CO	aw requir as been si 2 should	ompieted								24a. Was a	n 24b. \	Were aut	opsy findings available
Re	9 5 9	E								autops perform	ned/	death?	mpletion of cause of
ita		BeC	25. Was case referred to medical						26. Place of Deat				
<u>_</u>	S S	To E	examiner? 1 🗆 Yes 2 🛂 No	Hospital: 1 🗆	Inpatient 2 🗆 E	ER/Outpatier	nt 3□ DOA	Othe	4 Nursing Ho	me 5 ☐ Reside	ence 6 □Oth	er (Speci	fy)
0 0	ing Ph itter th ineral		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		c. Injury Work		28d. Describe ho	ow injury occur	ed	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		res 2 □No	006 1 /0			The second second
Division of Vital Records,	or All	Certification:	4  Homicide determined	build	of Injury - At hor ing, etc. (Specify	me, raim, str	eet, factory,	onice		City or Town		er or nur	al Route Number,
	Hospital 14 hours a Funeral I		29a Certifier 1 Certifyin P	nysician To the	best of my know	wledge, deat	e bemugge if	the tio	a, date and place.	and due to the e	ause(s) and wa	rinar as a	stated
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examone)	miner: On the b	asis of examinat ner stated.	ion and/or in	vestigation,	n my op	inion, death occur	red at the time, d	ate and place,	and due	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	-57					number	2	9d. Date signe	d (Month,	Day, Year)
							7	5	0115	N	farch 1	, 200	06
	5		30. Name and address of person who	o'	~ 211/	411 -	101.0	17	na. a	a) las			
	Acceptance of		31. Date filed (Month, Day, Year)	May F	Registrar's Signat	ture	Z 3	140	Rand	* ISTOWN	mo	21	133.
	Sta Regista		31. Date filed (Month, Day, Year) MAR 0 2 200	6 Alex	as D.	A STATE OF THE PARTY OF THE PAR	N. S. S. S. S. S. S. S. S. S. S. S. S. S.						
			111/11 / 14	-									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February Day 27 2006 ileen mne 1:00 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 F 22-14-105 Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f shov 10d. Inside City Limits injury or other traumatic event, the Medical Examinar must be notified at Completed by Funeral Director 1 Yes 2 No RKVIlle TIMORE filed within 72 hours after deeth with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Baltimore, Maryland 21215-0036 3111 Morelano HVO or Iteme 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 AnalyST. permit. Pages 1 and 2 should be file Depertment of Heelth and Mentel Hy Important: If item 27 is marked of the eny lightly or other traumatic event, spag. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ ieran unne lacy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Moreland - niece oanne HVO Harkville 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) emetery 21. Signature of Funeral Service Licenses 22. Name and Addr. ss of Facility PALTIMORE, MD 21234 Molny EVANS FUNERAL CHAPEL 8X00 HARFORD ND 23a. Part1. Enter the dise se, or omplications that cau ad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List inhi one cause in each lim. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** belimone /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician and for use as the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 completely filled in by the funeral director, pege 2 should be Completed 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an autopsy performed? res 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this access Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time. Jate and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Med cause of death (Item 23a) (Type, Print) 6 ians 10 v 31. Date filed (Month, Day, Year) 32 Bastrar's Signature State Registrar MAR 02

			1 - State of Maryland / State of Maryland /		artmen rtificate			nd Me		iene 2006	06229
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Carolyn Margaret Dawidowicz						March	01, 2006	9:50 P. M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location of	Death		4c. County of Death	
			Heritage Nursing Home of Dundalk			unda				Baltimore	
r	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to 217_12_0777 1 M 2 F 82	virthday) Yrs.	If Under Months	Days	tf Under 2 Hours	Min.	8. Date of Birth (Month, Day July 02	Year) 9. Birth	place (State or Foreign ntry)
ŀ	Director		217-12-0777 Substitution of Decedent						July 02	2,1923 Balt.	lmore,MD.
	land ow		10a. State 10b. County 10c. City, To	wn or Lo	ocation						10d. Inside City Limits
	Mary Ff sh	tor	Maryland Baltimore County   Spar	ks							1 ☐ Yes 2 ☐ No
	r 28e	lrec	10e. Street and Number		10f. Zip	Code			1	0g. Citizen of What Cou	intry?
	h witi	a D	40 Far Corners Loop			211	.52			United Sta	ates
	deal mme	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13.	Was Deced	ent of Hi	spanic Origi	in? (Spec	ify Yes or No- lican, etc.)	14. Race - Amer Black, White	
9	or It	y Fu	Armed Forces?  1 Never Married 2 Married  1 Yes, Gree		1 ☐ Yes		Specify:		,,	Specify: Wh	
21215-0036	ural'.	d by	3 Widowed 4 Divorced Year or Dates:								
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	a. Dece (Give	dent's Usua kind of wor	il Occupa rk done d re retired	ition <i>luri</i> ng most i )	of working	g	16b. Kind of Business/Ir	ndustry
7	withii ene. then	Jmc	Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a		Home M					Own Ho	ne
0	filed Hygi other	Ö	17. Father's Name (First, Middle, Last)				18. Mother	's Name	(First, Middle, I	Maiden Surname)	
Maryland	ild be lental ked ic ev	To Be	Lewis Schaffner				Carri	e St	ielper		
ary	shou and N	_	19a. Informant's Name/Relationship (Type, Print)	b. Maili	ng Address	(Street a	ın <i>d Nu</i> mber	r or Rural	Route Number	, City or Town, State, Zi	p Code)
Σ	and 2		Mrs. Jean C. Lopez (Step-Dau.) 4	0 Fa	ar Cor	ners	Loop	Sp.	arks,Ma	ryland 21	L52
ore	of He of He fiten		20a. Method of Disposition 1	of Dispo ery, crea	osition (Nan matory or o	ne of ther place	9)	Da	ite	20c. Location - City or T	own, State
Ě	Pag ment ant: I ury o		4 Donation 5X Other (Specify) Entombment Par	kwoc	od Cen	eter	у Ма	rch0	3,2006	Parkville	,Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itame 23e or 28e-f show eny Injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licensee from the Survice Licensee	Pe 23	Name and Pacefu 325 Yo	d Addres II Al ork F	s of Facility terna Road	tive Tim	s Funer onium,	al&Cremation	on Ctr.P.A. 21093
			23a. Ram. Enter the disease or complications that caused the death. Disnock, or head failure. Ust only one cause of each line.	not enf	ter the mod	e of dying	g, such as c	ardiac or	respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition ASPIRATI	ON	Pr	JEU	MON	VIA			Onset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. ASPIRATI  Due to (or as a consequence by LARGE Both Cause)	e of):		<u> </u>					
п	- Adminier		Sequentially list conditions, b. LARGE BO	WE	4	LLE	45				
1	sit set	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	3 01):	201						
V	and and II-tran	хап	that initiated events resulting in death) Last c. Due to (or as a consequence		UIX						
8760,	ate be executed whysician and the burial-transit	Ical E	(								
	ilicate g phy: as the	edic	0.								
Box 6	that the death certifics ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1☐Live birth 2 ☐Fetal dea	. <u>.</u> 2	75-4					23d. Date of deliv	ery
	death	ic la	in the past 12 menths?  1 ☐ Yes 2 ☑ No  4 ☐ Pregnant at time of death		∃Ectopic pr ∃ Other (sp					Month	Day Year
0	by th	hys	9 ☐ Unknown								
Records, F	The law requires that the to be a signed by the bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying c	ause give	n in Part I.			pacco use contribute to	the cause of death? bably 4  Unknown
00	awreas bee	Completed							24a. Was a		opsy findings available
æ	The lay	E							autops perform	ned? death?	ompletion of cause of
Vital	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical				26. Place o	of Death	(Check only on		
	Physic this ce al dire	To	examiner?  1   Yes   2   No   Hospital: 1   Inpatient   2   ER/C	)utpatier	nt 3 DC	A Othe	n 4 Turs	sing Hom	e 5 🗆 Reside	ence 6 Other (Speci	fy)
0	Attending Physiclan: or death. ector: After this certifically the funeral director.	ü.	27. Manner Death 1 Vaturat 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b	. Time o Injury		8c. Injury Work		1	3d. Describe ho	w injury occurred	
<u>sio</u>	tendi leath tor: / the fi	cat	2 Accident investigation 3 Suicide 6 Could not be		М		/es 2□N		26.1		7.5
Division of	or Attendate death Director:	Certification:	4 Homicide  determined  28e. Place of Injury - At home, building, etc. (Specify)	farm, str	reet, factory	, office		28	City or Town	reet and Number or Rur n, State)	ai Houte Number,
_	To the Hospital or Attending Physiclan: The i within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination a and manner stated.	and/or in	vestigation,	in my op	inion, death	n occurred	d at the time, d	ate and place, and due t	o the cause(s)
	o the	Med	29b. Signature and title of certifier		290	. License	number		2	9d. Date signed (Month,	Day, Year)
	r > ₩ 0		Savinder & Julie 1	10		D 2	7/8	8		3/2/06	
	6		30. Name and address of person who completed cause of death (Item 23a	) (Type,	Print)	beco	, ,	ממו	MK	21272	<i>L</i> (1)
\$70 miles	Sta Registr		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a SVI AUEL K JUNG 2 MG.  31. Date filed (Month, Day, Year)  32. Tegistrar's Signature	A	nede		- 9	VII			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month 16:24 M AROLA **Physician** 1 humas 2006 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner AMedical BALTIMORE CONTER Ltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**℃**M 2□ F 212:44.4605 Director 09.18.1946 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits show traumatic event, the Madical Examiner must be notified at NA Baltimore 1 MYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Circle 21215 Edgecomb 2530 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "na Baltimore College (1-4or 5+) Elementary/Secondary (0-12) Transit Service Driver 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Essex Duncan Eloise Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 stands to Department of Health ar Important: If Item 27 Is any injury or other trausone. Sutter Youru Avenue St. LOUIS MD 63133 David Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 02.27.06 Crownsville MD \* 4 □ Donation 5 □ Other (Specify) rownsville 22. Name and Address of Facility Vaughn C. Greene Funeral Services 4105 York Road Baltimore MD 21212 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hemorrhag Crunia disease or condition resulting in death) /Medical Examiner Curce fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛂 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 MNatural death, 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb 20, 2006 AU4176435D16758

Registrar

State

31. Date filed (Month, Day, Year)

MAR 0 2 2006

10 N. GIERNE St, Bultimore, MD ZIDI

ress of person who completed cause of death (Item 23a) (Type, Print)

Dingman /

			1 - For State Registrar	State of N	Marylan		artmen <i>rtificate</i>			and M	lental Hyg	iene eg. No.	16 (	06231
	Physici /Medic		Decedent's Name (First, Middle, Las	LO		DICK					2. Date of Deal Month February	Day	Year 2006	3. Time of Death 8:00 Р м
)	Examin		4a. Facility Name (If not institution, give Somerford Place  5. Social Security Number 6. Se			last birthday)	4b. City,	Col	Location oumbia		g Date of Birth		Howar	_
. 341	Funeral Director		188-32-0964 10 Decedent	M 2√_XF	64		Months	Days	Hours	Min.	8. Date of Birth (Month, Day, May 23,	1941	Cou	place (State or Foreign ntry) eesport, PA
	he Marylan Ba-f show	ector	Maryland How	ard		y, Town or Lo Columbi	.a							10d. Inside City Limits 1 ☐ Yes 🏋 🖫 No
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show super injury or other treumatic event, Ite Medical Examinational by incilling all once.	Funeral Director	Somerford Place 8220 Snowden Rive 11. Marital Status	Attried Force	5!	.S. 13.	Vas Deced		21045 spanic Orig		ecify Yes or No- Rican, etc.)		USA Race - Americans - America	can Indian,
5-0036	72 hours aften natural, or least exemple	eted by F	1 Never Married 2 Married  ★☆ Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grav	1 ☐ Yes XI If Yes, Give Year or Date ucation de completed)	_	16a. Deced	1 ☐ Yes a dent's Usua kind of wor	I Occupa		of work	ina	Spec 16b. Kind of	. W	hite
Maryland 21215-0036	filed within Hygiene. other then " ent, the Mar	Be Completed	Elementary/Secondary (0-12) 12 years 17. Father's Name (First, Middle, Last)	College (1-4d	or 5+)	life.	DO NOT us	rica	1		e (First, Middle, I		isable	ed
larylan	should be and Mental is marked (	ToB	Lawrence Spiche 19a. Informant's Name/Relationship (7	ype, Print)			-		ind Numbe	er or Rura	Shields a/Route Number		vn, State, Zip	o Code)
nore, M	ages 1 and 2 nt of Health I: If Item 27 r or other tre		Doulgas R. Spiche:  20a. Method of Disposition  14Deurial 2 Cremation 3 C	Removal from Sta	to C	Place of Dispo	sition (Nan	ne of ther place	9)			20c. Locatio		
Baltimore,	permit. P. Departme Important eny injury once.		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen:		the	22	. Name an	d Addres	s of Facilit	v				and 21045
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	sed the deat in line.	EV	er the mod	e or dynn	y, such as	Cardiac (	- espiratory arm	est,	ridi y i	Approximate Interval Between Onset and Death
8760,	ficate be executed physicien and is the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq	,								
P.O. Box 6	death certi e ettending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta at time of c	ıl death 3□	Ectopic pro						Date of delive	ery Day Year
	w requires that the been signed by th should be detache	ted by Pi	Part II. Other significant conditions or	ontributing to deat	n but not res	ulting in the u	nderlying ca	ause give	en in Part (.			oacco use co		he cause of death? bebly 4 @Unknown
of Vital Records	The law ete has b page 2 s	e Completed	25. Was case referred to medical						00 B)			ned?	prior to co death?	opsy findings available impletion of cause of
ion of Vi	ding Phys h. After this funeral di	ToB	examiner?			ER/Outpatier 28b. Time of Injury		8c. Injury Work	at ⊟Nu	rsing Ho	me 5 ☐ Reside 28d. Describe ho	ence 6 🗆 C		(5)
Division	in the second	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building,	etc. (Specia	(y)					City or Town	n, State)		al Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Phyone)  2 Medical Examona  29b. Signature and title of certifier	ysician: To the be liner: On the basis and manner	s of examina	owledge, death ation and/or in	vestigation,	in my or	e, date and pinion, dear	d place, th occurr	red at the time, d	ause(s) and ate and plac 9d. Date sig	e, and due t	o the cause(s)
	/		30. Name and address of person who o	completed cause of	of death (Iter	n 23a) (Type.		0	27:		f	36	1/06	
	Sta Registr	-	JAMES P.  31. Date filed (Month, Day, Year)	R1041	strar's Signa	en up	33	33,	N, CA	thu	NT IT	*325	BALT	74218 24218

			For State Registrar	State of	Maryland / Dep Ce	artment of rtificate of		nd Me		ene 0 C	16	06232
	Physicia	an	1. Decedent's Name (First, Middle, La		rt Colin Davis	•		2	2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	40	4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of	Death	Febru	ary 23, 20 4c. County		3:50 p.m. <sup>M</sup>
¥1	Examin	er				40. Olly, 10111,	0. 2002.0 0.	Colu	mhia	, ,		ward
	Funeral		5. Social Security Number 6.5	86 Good hu	nters Ride 1. Age (In yrs. last birthday,	If Under 1 Year			B. Date of Birth (Month, Day, Y	(nar)		place (State or Foreign
34	Director		218-36-2932	M 2□F	67 Yrs.	Months Days	s Hours					
	p.		Usual Residence of Decedent						January 5,	1939		shington, DC
	show	_	10a. State 10b. County		10c. City, Town or L	ocation						0d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director		oward		1.27.71.0.1	Columbia	a	10	g. Citizen of V	411 -4 0	(
	with the	D	10e. Street and Number			10f. Zip Code	040	4.5	100	g. Citizen or v		,
	eath	era	6186 Good Hunters R		dent Ever in U.S. 13.	Was Decedent of	210 Hispanic Orio		ifv Yes or No-	14. Rac	U.S e - Americ	.A. can Indian,
	r iten	Funeral	1 Never Married 2 Married	Armed For 1 XI Yes If Yes, Give	ces?	If Yes, specify Cu	ban, Mexican,	Puerto Ri	can, etc.)	Blac	k, White,	etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or Items 23a or 28a-f show event. Ite Medical Examinat must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes: - Qto	1 ☐ Yes 2 🗷 No	o Specify:			Specify	<i>/</i> :	White
2-0	72 ho natur	Completed	15, Decedent's E (Specify only highest gr		(Give	edent's Usual Occu	e during most	of working	16	6b. Kind of B	usiness/In	dustry
21	within ene.	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+) /ife.	DO NOT use retir				Orbital	Scienc	es Corporation
	Hygie Hygie other t		17. Father's Name (First, Middle, Last	2		Prii	ncipal Buy	***	First, Middle, Ma	aiden Suman	ne)	
anc	Mental H Merked of arked of	Be					10111101	0.14.110				
Maryland	2 should be filed within and Mental Hygiene, is marked other than aumatic event, Ita M	은	19a. Informant's Name/Relationship	Henry Davis	19b. Mail	ing Address (Stree	et and Number	r or Rural I	Marjorie Route Number, (			
S	and 2 sealth ar n 27 is ner trau		Mrs Linda Davis		Vife	6186 Good I	Hunters R	ide Col	lumbia Mar	vland 21	045	
ē,	- 子 N +	1	20a. Method of Disposition		20b. Place of Disp			Da		Oc. Location -		own, State
E	Pages nent of int: if it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		state	bia Memoria		02/2	8/2006	Clar	ksville.	Maryland
Baltimore,	it.		21. Signature of Funeral Service Lice	Jsee D		2. Name and Add		1				
Δ_	Depi Impe		Mullian	hershi	VI	Slack	Funeral I	Home,	P.A. ike Ellicott (	City MD	<del>91048</del>	
4			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that ca one cause on ea	tosed the death. Do not er ach line.		4 .					Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a thel	astatic	Tell	bled	de	Con	e	1	5 45
	/Medical Examiner		resulting in death)	Due to (	or as a consequence of):	1						28
100		20	Sequentially list conditions, if any, leading to immediate	b. — Due to (c	or as a consequence of):							
1	nted Insit	il i	cause, Enter Underlying Cause (Disease or injury	,	,							
v ´	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (	or as a consequence of):							
8760,	cate be executed physicien and the burial-transit	dical		d								
9		Aedi	IF FEMALE:								-	
Вох	ith ce itendii or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi		□Ectopic pregnan	псу				te of deliv	ery Day Year
0.	the all	slcl	1 Yes 2 No	4□Pregna 9□Unkno		Other (specify)						,
<u>α</u>	The law requires that the death certific ate has been signed by the attending proage 2 should be detached for use as	e.	Part II. Other significant conditions	contributing to de	ath but not resulting in the	underlying cause o	given in Part I.		23e. Did toba	icco use cont	ribute to t	he cause of death?
Records,	signe d be	d by		•					1 ☐ Yes	2 No	3 🗆 Prot	pably 4 Unknown
Ö	w requir been si should	lete							24a. Was an	24b.	Were auto	ppsy findings available
Re	sician: The law scertificate has t lirector, page 2 s	Completed							autopsy	ed?	prior to co death?	mpletion of cause of
Vital			25. Was case referred to medical				26. Place	of Death /	Check only one		1 🗌 Yes	2   N0
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o t	g Phy er this seral c		27. Manner of Death	28a. Date o	of Injury h, Day Year) 28b. Time Injury	of 28c. in			3d. Describe hov			
io	Attending in death.	atic	1 Natural 5 Pending 2 Accident investigation	ก			Yes 2 N	No				
Division	or Att	Certification;	3 Suicide 6 Could not determined	256. Place	of Injury - At home, farm, s ng, etc. <i>(Specify)</i>	treet, factory, offic	8	28	Bf. Location (Stre City or Town,		er or Rur	al Route Number,
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	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	nysician: To the miner: On the ba and manr	best of my knowledge, dea usis of examination and/or it per stated.	nvestigation, in my	opinion, deat	h occurred	d at the time, dat	ise(s) and mi le and place,	anner as s and due t	o the cause(s)
	o the	Me	29b. Signature and title of certifier	a a tright		29c. Lice	nse number		296	d. Date signe	d Month,	Day, Year)
	F S F 0		→ Oc./			A 4	L113 "	9	2	124	100	0
	1/2		30. Name and adoles of person who	completed caus	e of death (Item 23a) (Type	e, Print)				1	1	
			Knight, Clement MD	11055 Little	Patuxent Pkwy. (	Columbia, MI	D 21044			#V 11.	17	
1	Sta		31. Date filed (Month, Day, Year)	E	egistrar's Signature	Card 5						
100	Regist	(ell	MAR n 9 1	THIS BY	18. 10 1 6 14 July	The same of the sa						

Benjamine Evans Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1,perfe. 9853,3/13/06 TI State of Maryland / Department of Health and Mental Hygiene 06-01406 CT1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Benjamin Phillips Evans, Jr. 3. Time of Death **Physician** Benjamin P. Evans Jr Month Year February 25 2006 0610 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-17-5294 1XM 2□ F 25 Yrs. Director 14 1981 Maryland Usual Residence of Decedent with the Maryland 10b. Count 10a State 10c. City, Town or Location 10d. Inside City Limits in then "naturel; or items 23a or 28a-f ehov the Medical Examinar must be notified at Maryland Anne Arundel Annapolis 1 X Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1311 Van Buren Dr. 21403 USA 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Co. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Circuit Court 12th es 1 and 2 should be filed v of Heelth and Mental Hygie f Itam 27 ie marked other t r other treumatic event, III per 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin P. Evans Sr. Jacqueline Parker ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Evans(Mother) 1311 Van Buren Dr. Annapolis, Md. 21403 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Hardiele C. K. 60 Soty of M. 6 M. 6 at 1 a 1 permit. Pages 1
Depertment of H
importent: if its
eny injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Park 4 ☐ Donation 5 ☐ Other (Specify) 3-3-06 Annapolis, Md. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. Lavry Treese MOOTS 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. page 2 should be deteched 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 17 Yes 2 □ No 24a. Was an autopsy performed? certificete 2 No Yes Attending Physician: After this certifice funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Pay Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation O 200 within 24 hours efter death. To the Funarei Director: A 5 06 1 Yes 2 No 2 2 Accident Subject 8 completely filled in by the 3 ☐ Suicide Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2XXXedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Cluck only one) ţ, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar of death (Item 23a) (Type, Print)

32. Registrar's Signature

rson who complet a cause

CARON LOCK

31. Date filed (Month, Day, Year)

OCME

111 Penn Street

February 25, 2006

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician February 27, John E. Frye 2006 2:54 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 616 - A Harborside Drive Joppa Harford 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 XM 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Yrs. 79 219-22-1019 Director Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itame 23s or 28e-f show It s Medical Exact armest be netitied at 1 ☐ Yes 2 ☐ No Directo Maryland | Harford Joppa 10g. Citizen of What Country? 10e. Street and Numbe. 10f. Zip Code 616 - A Harborside Drive 21085 filed within 72 hours after death v Hygiene. other then "naturel", or Iteme 23s USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 50-53 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Supervisor 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill iment of Health and Mental H tent; If item 27 le marked otl 2 Edward Frye Ruth L. Anthoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 leeny injury or other training 1454 Harford Square Drive Robert Gavlinski/Son Edgewood, MD 21040 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/28/06 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service L Cremation Society of MD, Inc. Edward A Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascular Disease 20 Years /Medical Due to (or as a consequence of) Examiner Hypertension 20 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit Hyperlipedemia 15-20 Years that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten edetached for u 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown Exogenous Obesity peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed Yes 2 No 1 ☐ Yes the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ▼Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and D0016036 February 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 520 Upper Chesapeake Drive, Suite 201, Bel Air, MD 21014 Dean L. Vasser, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Booker Registrar 2006

		·	For State Registrar	State of Maryland		rtment of He			giene	06235
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give si	1 500		4b. City, Town, or			4c. County of	. 1 A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24 H	rs. 8. Date of Birt	h s	Birthplace (State or Foreign
	Director			M 2) SQF	Yrs.	Months Days		in. (Month, Da)	2606	Country) MD
	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loca	ation		<u> </u>		10d. Inside City Limits
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	be filed within 72 hours efter death with the Maryland Hygiene. Hygiene. do ther then "natural", or Items 23a or 28a-f show other then "natural", or Items 23a or 28a-f show event, the Medical Examinar must be inclified at	i Director	10e. Street and Number 1624 Harts da	te Road		10f. Zip Code	1230		10g. Citizen of Wh	at Country?
	r death	Funerai		Was Decedent Ever in U.S. Armed Forces?		as Decedent of His Yes, specify Cuban	panic Origin? , Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		American Indian, White, etc.
036	ours efte ral', or It Evernin	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>⊠</b> No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	Black
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Mary	2 sh and ls m		19a. Informant's Nam elationship (Typ	e, Print) (Forther)	19b. Mailing	Address (Street ar	nd Number or	Aural Route Numbe	r, City or Town, St.	ate, Zip Code)
	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. Plac	ce of Disposi	tion (Name of atory or other place		Date	20c. Location - Ci	
altimore,	Pag nent ent: I	į	1 Surial 2 Cremation 3 Re  `4 Donation 5 Other (Specify)	movanirom State   •		onal Pan	U 02	· 28.06		blown, MD
Ball	permit. Pag Deportment Importent: any njury o		21. Signature of Funeral Service License Www.	" Suit	3	Name and Address	of Facility  Koa	a Bauti	ral Sev	Vices 1D 21212
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0	ding Phys h. After this funeral dir	on: T	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work?	at		ow injury occurred	
Division	ttendi death. stor: A / the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	e farm stree		es 2 No	28f Location /S	treet and Number	or Rural Route Number.
2	el or A	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	0, 14,111, 01,00	or, ractory, critico		City or Tow		
	Tc the Hospitel or Attending P with the 24 hours effer death. To the Funerel Director: After the completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knowle er: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the time estigation, in my opi	e, date and pla nion, death oc	ace, and due to the courred at the time, o	ause(s) and mann date and place, and	er as stated. If due to the cause(s)
	With hin complete the complete	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (/	i
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	M			apleted cause of death (Item 2	3a) (Type, Pi	rint)		362 ose Ase		Com.
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	10 820		enica	oce Ave	Dalting	Je, IIII
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	Physici /Medic		1. Decedent's Name (First, Middle, Las Stacy	t)		Fraz	ier	2. Date of De Month Februard	Day	Year 2 <i>006</i>	3. Time of Death 00:48 M
	Examin		4a. Facility Name (If not institution, give The Juhns Hopkins	s Hospital		Baltim	Location of Death		4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Security Number 217-17-3930 Usual Residence of Decedent		8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 03 2	y, Year)	9. Birthpla Count M I	
	a-f ehow	ctor	10a. State 10b. County MD NA	100	c. City, Town or Lo Baltin					10	0d. Inside City Limits 1 X Yes 2 □ No
	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department: If term 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Madical Examinar mast be notified at pince.	Funeral Director	10e. Street and Number  7482 Catterick  11. Marital Status	Court  12. Was Decedent Ever	in U.S. 13.		1244	pecify Yes or No		S • A •	
0000	nours after dural, or iter	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	Specify:	Rican, etc.)	Specify	рта	ck
-61717	illed within 72 hours after Hygiene. other then "natural", or ite ent, Ira Medical Examina	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12th grade		(Give	dent's Usual Occup kind of work done of DO NOT use retired outh Cou	during most of world	king	16b. Kind of B	usiness/Ind	lustry
yland	Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last)  Eric Frazier  18. Mother's Name (First, Middle, Maiden Sumame)  Jennifer White								
E, Mai	1 end 2 sh Health and em 27 ls m ther traum		19a. Informant's Name/Relationship (7)  Eric Frazier  20a. Method of Disposition	SrFather	1000	Southri	.dge Roa			, Md	21228
Daltimor	nit. Pages partment of cortant: If It Injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Function 21.	r)	Wood		3/3/		Baltim		
ă	Dapa Impo any II	13	23a. Part1. Enter the disease, or compshock, or heart failure. List only	blications that saused the one cause on each line.		2. Name and Addre F F F 300 Waba ter the mode of dyin					21215 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Sepsion Due to (or as a co	nsequence of):					C	Onset and Death  Adays  months
,00	ate be executed hysicien and the buriat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co		5					WIOTINS
.O. DOX 00/00,	The law requires that the death certificate be executed are hes been signed by the attanding physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								ry Day Year
ecords, r	equires tha en signed ould be de	þ.	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did t		tribute to the	e cause of death? ably 4  Unknown
	80	Completed						24a. Was auto pento 1 🗆 Yes	psy ormed?	Were autop prior to com death? 1  Yes	osy findings available inptetion of cause of
01 416	Physician: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1 Inpatient	2 ER/Outpatier		4   Nursing H	ome 5 Resi	dence 6 □Oth		)
VISION	To the Hospitel or Attending Physician: The within 24 hours atter death.  To the Funeral Director: Atter this certificate his completaly filled in by the funeral director, page	Certification;	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28e. Place of Injury -	At home, farm, str	M 1□	y at k? Yes 2 □ No	28f. Location (	how injury occur		Route Number,
Ś	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	20	29a. Certifying Ph	building, etc. (S ysician: To the best of m niner: On the basis of exa	y knowledge, deat	h occurred at the tir	ne, date and place	City or To	cause(s) and ma	anner as sta	ated.
	To the H within 24 To the F complets	Medica	29b. Signature and title of certifier  Anu Gupta,	and manner stated.		29c. Licens			29d. Date signe	ed (Month, E	Day, Year)
	4		30. Name and address of person who a	completed cause of death	(Item 23a) (Type, Ospital, (	Print)	· · · · · · · · · · · · · · · · · · ·				
DH.	Sta Registi	ar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	parks					
<i>⊶</i> r1/\	1 1 Nev 1/2	501			ORIGI	NAL					

			1 - For State Registrar	of Maryland / Dep	partment of H		lental Hygie	ZHIII	06237		
	Physici		Decedent's Name (First, Middle, Last)	na Fiel	els		2. Date of Death	Day Year	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give street and S+ C-112 abeth N	mumber) Cente	~	7 1		4c. County of Death			
	Funeral Director		5. Social Security Number  6. Sex  1 M 3  Usual Residence of Decedent	7. Age In yrs. last birthda F 85 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 12 20	9. Birthy Cour	place (State or Foreign ntry) NC		
	laryland show	o.	10a. State 10b. County  MD NA	10c. City, Town or Balti					l od. Inside City Limits		
	28a-f	Director	10e. Street and Number	Daici	10f. Zip Code		10g.	Citizen of What Cou	21		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel; or items 23a or 28e-f show other treumetic event, if a Model Examinational be notified at	by Funeral DI	1 Never Married 2 Married 1 Yes		21 3. Was Decedent of Hill Yes, specify Cuba	216 ispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	IJ.S.A.  14. Race - American Black, White,  Specify:			
15-0036	in 72 hour "naturel" "Luicul Ex	Completed b	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Dec	cedent's Usual Occupa ve kind of work done of DO NOT use retired	ation during most of worki	ng 16b	o. Kind of Business/In altimore	dustry		
2121	2 should be filed within and Mental Hygiene. Is marked other then "eumetic event, Ite Wes	Com	12th grade 4y	ge (1-4or 5+)	Teacher			ublic Sc	hools		
and	d be fill ental H kad oth c evan	3e	17. Father's Name (First, Middle, Last)  McKinley Nicholson			Mazie 1	(First, Middle, Maid	den Sumame)			
Maryland	2 should and Men Is marks eumetic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street a		<del>-</del>	ity or Town, State, Zip	Code)		
	1 and 2 Health tem 27 othar tr	š	Marva Randolph-Daug	20b. Place of Dis	O Hall A			Md 21 Location - City or To	060 own, State		
mor	permit. Pagas 1 and. Department of Health Important: If item 27 any injury or othar tr onca.		1 Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State	rematory or other plac ${f 1}$ ${f Baptis}$	.	′4/06 т	illery,	NC		
Baltimore,	permit. Pagas Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	ss of Facility	Baltim	•	21215				
33	Physician /Medical	2. Y.	23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	on each line.  Oronary a	enter the mode of dyin	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death  V C W S		
	Examiner		Due to (or as a consequition of):  Sequentially list conditions,  b. ———————————————————————————————————								
8760, Ø	ate be exacuted thysician and the burial-transit	Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):  to (or as a consequence of):			7)				
O. Box 6	law requires that the death certificate be exacuted as been signed by the attending physician and 2 should be detached for use as the burial-transit	yslclan/Med	in the past 12 months?		B Ectopic pregnancy			23d. Date of delive Month	ery Day Year		
٥.	quires that n signed build be deta	d by Pr	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause give	en in Part I.		co use contribute to t	14		
I Records,	The ate his page	Completed by	Thypothyroidism anemia	1			24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of		
25. Was case referred to medical examiner?  1. Vas 25 No.									541		
of	> 0 0	tlon: To	27. Manner of Death 28a. D	ate of Injury 28b. Time  Month, Day Year) Injury	of 28c. Injury		28d. Describe how i		<i>y)</i>		
Division	al or Atten after dea I Director d in by the	Certification;	3 Suicide 6 Could not be 28e. P	lace of Injury - At home, farm, uilding, etc. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	(Check only Medical Examiner: On the	o the best of my knowledge, de ne basis of examination and/or nanner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier	1 mo	29c. License	= number	V	Date signed (Month,			
	V		30. Name and address of person who compared Mina Vi 3 3 20 D	cause of death (Item 23a) (Type MS M A V eV	ne, Print)	1timore	Mary	bruary.	1227		
	Sta Regista		31. Date filed (Month, Day, Year) 3 MAR 0 2 2006	2. Redistrar's Signature	John						

		•	For State Registrar	State of Ma	-		t of Health and e <i>of Death</i>	Mental Hygier	CUU0	06238
	Physici	an	1. Decedent's Name (First, Middle, Las	1)	5,	IleR			Day Year	3. Time of Death
y	/Medic		4a. Facility Name (If not institution, give	street and number)	7 9		Town, or Location of Dea	February ath	25, 200 4c. County of Deat	4
			Union memor		PITAL		1 Year   If Under 24 Hr	S O Date of Birth		A
	Funeral Director		5. Social Security Number 6. Sec. 231 – 36 – 3256	M 2 F	(In yrs. last bin		Days Hours Mir		929 V:	hplace (State or Foreign nuntry)
pue	***		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Maryl	e-f eho	tor	md. N	1A	/	3al	timor	<u>ي</u>		yes 2 □ No
1215-0036 within 72 hours after death with the Maryland	ital Hygiene. Id other than "natural", or Items 23a or 28a-f ehow event, the Medical Exemer must be motified at	Funeral Director	10e. Street and Number	I for d	Ave	10f. Zip	Code 2 / 2 /	8 10g.	Citizen of What Co	ountry?
r death	ems 20	Inera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Deced	lent of Hispanic Origin? (	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
5-0036 72 hours afte	al, or it	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	0	1 ☐ Yes	No Specify:		Specify:	3 (ack
15-0 n 72 ha	"natur edicel	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Usua (Give kind of wor life. DO NOT us	rk done during most of w	vorking 16b	Kind of Business	Industry Factured .
N g	and Mental Hygiene. Ie marked other then aumatic event, the Mi	Comp	Elementary/Secondary (0-12)	College (1-4or 5+	+)	STEPL	work			
\$ ≥	Mental H) arked oth atic event	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, Maio	len Sumame)	
aryla : shoutd	and Me e mark	T <sub>0</sub>	19a. Informant's Name/Relationship (1	'ype, Print)	19b		(Street and Number or F		y or Town, State, 2	Zip Code)
6, <b>M</b>	5 ~ 5	1	EUG Fuller -	daughte		Disposition (Nan	vd mont Ar		Ho, mdi	2/2/3/9 Town, State
altimore,	nent of I int: If It iry or o		1 Surial 2 Cremation 3 4 Donation 5 Other (Specify		cemeter	y, crematory or o.	L Cem 3	03/06 1	eindal	k, md,
Balti permit.	Department of Heali Important: If Item 2 eny injury or other once.		21. Signature of uneral Serve Licen			22. Name an	P. march	20 Fredrik	ion Pas	s md=1229
			23a. Part . Exper the disease, or companies shock or heart failure. List only	olications that caused to one cause on each line	the death. Do r				- page 1	Approximate Interval Between
	ysician Medical		Immediate Cause (Final disease of condition resulting in death)	a. Sep	sis					Onset and Death
	aminer			Due to (or as a	consequence	nid Nid				
1 8	sit	niner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a	es leupéenus l	J):				
8760, <	en and rial-trar	Examin	that initiated events resulting in death) Last	C. Due to (or as a	consequence	of):				_
58760, licate be ex	physicien and s the burial-transit	edicai		, d						. 3
Box 6	ettending i		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 ⊟Ectopic pr	egnancy		23d. Date of de	
O. But the deat	by the ett	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at t		5 Other (sp			Month	Day Year
O E	pe de	þ	Part II. Other significent conditions of	ontributing to death bu	t not resulting in	the underlying c	ause given in Part I.	9	co use contribute to	the cause of death?
Records, The law requires t	been si	leted	Diabetes		•			24a. Was an	24b. Were au	utopsy findings available
The la	his certificate has t il director, page 2 s	Completed	- 11100(0)					autopsy performed 1 ☐ Yes 2 ☑	death?	completion of cause of
Vita	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	100		Other	eath (Check only one)	- 501 40	
Division of Vital	h. After this funeral de	n: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 ☐ Inpatier  28a. Date of Injury (Month, Day)	7 7		28c. Injury at Work?	Home 5 Residence 28d. Describe how in		cify)
Sior	death. ctor: Af y the fur	icatic	2 Accident investigation 3 Suicide 6 Could not be	1		М	1 Yes 2 No	28f. Location (Street	and Number or Pi	ural Boute Number
Div talor A	rs after deatl al Director: ed in by the	Certification:	4 Homicide determined	building, etc.	. (Specify)	ini, street, factory	, onice	City or Town, S	tate)	Todo (Vanissi)
• Hospi	within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exen	ysicien: To the best on the basis of and manner state	examination an	e, death occurred d/or investigation	at the time, date and pla- , in my opinion, death oc-	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier	1 4	. 7	290	: License number	29d.	Date signed (Mont	h, Day, Year)
,	Λ.		30. Name and address of person who	completed carles of the	MD (Itom 33a)	(Type Print)	2006118	51 3	25 6	
	V		Soumya Ganc	upathy,	MD (Item 23a)	Union	Memorial	Hospital	Balti	more, MD
	Sta Registr		31. Date filed (Mbnth, Day, Year)  MAR 0.2.		r's Signature	Basil	B	1		/

			State of Maryland / Department of Health and M 1 - For Amend Item 26 per verb., G853, 03/02/06dbb Per verb.	Mental Hyg	giene 006	06239			
	Physicia	20	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day Year	3. Time of Death			
	/Medic		MARIE E. FLANK	2	15 06	8:05 p м			
)	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death  109 Croftley Road  Lutherville		4c. County of Dea				
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimor	thplace (State or Foreign			
4.	Director		216-03-6462 1 M 2 F GE Yrs. Months Days Hours Min.	March 2	6,1917 Per	nnsylvania			
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
	Maryi ind	to	Maryland Baltimore Lutherville			1 ☐ Yes 2 No			
	or 28e	lrec	10e. Street and Number 10f. Zip Code	1	log. Citizen of What C				
	ath w	ral	109 Croftley Road 21093		USA				
	item item	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi				
920	72 hours after death with the Maryland natural, or Heme 23a or 28e-f show itcal Examinat must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give X 1 □ Yes 2 ☑ No Specify: Year or Dates:		Specify: Wh	ite			
2-0	"natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ing	16b. Kind of Business	s/Industry			
121	within lene. then	mp	Elementary/Secondary (0·12) College (1-4or 5+) Home Maker						
d 2	other i		17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Own Home Maiden Sumame)				
ılan	should be ind Mental s marked o umatic eve	To Be	Francis Gebhart Blanche	Nu	nemaker				
Maryland 21215-0036	2 shoul and Me is mark raumati		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rura</i>						
e,	iges 1 and of of Health it is		Jerome John Frank / Son 109 Croftley Road Luth  20a. Method of Disposition (Name of		20c. Location - City of				
nor			1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Hilltop Service Corp. 2/20		Towson, M				
Baltimore,	permit. Pa Departmer Important any injury		21. Signature and Address of Facility	., 66		rk Road			
ä	Depa Impo any is		Ruck Towson Funeral	Home, I	nc.Towson,	Md.21204			
42			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List poly one cause on each line.			Approximate Interval Between Onset and Death			
(v. )	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)						
	Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Dile	6 Le	MANY YEAR			
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			, , , , , ,			
	be executed iician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):						
8760,	ate be executed hysician and the burial-transit	ical E	Due to (or as a consequence of).						
	ificate g phys as the	edic	d						
Box 6	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de				
Э. Ш.	0 0 0	sici	in the past 12 months?  1		Month	Day Year L∡			
P.O.	that thed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?			
rds	w requires that the death been signed by the atte should be detached for	d by	Diabetel	1 🗆 Y	es 2 No 3 ₽	robably 4 DUnknown			
Division of Vital Records,	The law requires that the ate has been signed by th page 2 should be detache	Completed	Hyer Bullan	24a. Was a	n 24b. Were a	utopsy findings available completion of cause of			
Ä	The lavate has	E O		perfor	med? death?				
Viťa	Physician: The this certificate h ral director, page	Be	25. Was case referred to medical examiner?  Hospital: Other: Other:			Conta			
ot	는 는 =	٦. ح	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 EVOA  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	me 5 Reside	ence 6 <b>X</b> Other (Spe	Residence			
ion	Attending r death. ector: After by the funer	atior	27. Manner of Death  1. Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Work?  1 □ Yes 2 □ No	note					
ivis	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	treet and Number or R	ural Route Number.			
	urs aft arel Di		N /4	MA					
)	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	and due to the cred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)			
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mon				
			D3336,		2/17/0	06			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	À	1110				
	Sta	te	Albert D, Gerelan O 35 = PADOR A (2) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1026	min , and )				
9-1	Registr	-167	MAR 0 2 2006 A A A A						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Date Month 3 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:15 PM Frank John Guttman 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Frankin Square Huspita 5. Social Security Number 6. Sex 4b. City, Town, or Location of Death Examiner Rosedale TMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec . 1, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 □ F 75 213-28-4660 Maryland Vrs Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exemples must be notified at MD Baltimore 1 Yes 2 No Director Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 904 N. Essex Ave. 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Worker GM 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Guttman Olga Grada 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Importent: If item 27 is any injury or other treu once. Mary J. Guttman /wife 904 N. Essex Ave. Baltimore MD Itimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Gardensoffaith 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/06 Rossville MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 3<u>00 Mace</u> Ave. Baltimore MD 21221 23a. Part1. Enter the disease shock, or heart failure. List omplications that caused the de Htt. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Movine Shut **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) anding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy performed? 1 Yes 2 No 2/1/No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 1 Yes 3□ DOA luneral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c, Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 ☐ Accident filled in by the within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Print) 9000 Franklin 31. Date filed (Month) Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

MAR 0 2 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Ethel May Green 3:40pm 02 25 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center IONSON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 09 · 01 · 1926 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 220.22.9853 1 ☐ M 2 💢 F MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at MD NIA Baltimore 1 MYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2880 W. Garrison Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: Black Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other treumetic event, the Medicanone." College (1-4or 5+) Elementary/Secondary (0-12) Domestic Laborer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mani E. Williams Dovsei Joshua 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Purdue Avenue Green Balto. MD 21239 1 Son 5405 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition or other place) cemetery, crematory 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimone MD Cemetery 03/04/06 4 ☐ Donation 5 ☐ Other (Specify) Trinutu 21. Signature of Funeral Service Licensee Vaughn C. Greene Funeral Semicos 4909 York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9ASTri MICER months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit end resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. ete has been signed by the attending physicien page 2 should be detached for use as the burta Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy performed? 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.
To the Funeral Director: After completely filled in by the funeral 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

Registrar

31. Date filed (Month, Day, Year) MAR 0 2 2006

30. Name and address of person completed use (I death (Item 23a) (Type, Print)

29b. Signature and title of certifier

N. Charles St. 6701 BINC 32 Registrar's Signature Elecar

us

Abruary 25, 2001

29c. License number

20626

29d. Date signed (Month, Day, Year)

Bolto and 21204

1-ebruary 26,2006

				State of M							-	00010
		•	For State Registrar			Cei	rtificate of	Death		Reg. N	6.000	06243
			1. Decedent's Name (First, Middle, Las						2. Date of		V	3. Time of Death
	hysici/ Medic		LILLIAN 6	TILLES'	PIE	•			FEBR		S 200 G	10:53 P.M.
	Examin		4a. Facility Name (If not institution, give	e street and number)	)		4b. City, Town,	or Location of De	eath	4	. County of Deat	h
			HARBOR HOSP	ITAL			BALTI	MORE				
	ıneral		5. Social Security Number 6. S	ØX 7. A		last birthday)	If Under 1 Year Months Days		Ain. (Month	f Birth , Day, Year	9. Birti Co	hplace (State or Foreign untry)
Dir	rector		213–30–8375 1 Usual Residence of Decedent		74	Yrs.			Sept.	9,1931	Ba1	timore,MD
and	A H		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Mary	43	ō	MD			Baltim	ore					1 XYes 2 □ No
the state of	88	rec	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	untry?
1215-0036 within 72 hours after death with the Maryland ene.	38.0	Funeral Director	1444 Cooksie St	treet			2123	0		Ţ	JSA	
deat		ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin?	(Specify Yes o	r No-	14. Race - Ame Black, White	
မှု မြောင်း	P I	F.	1 Never Married 2 Married	1 Tes 2			1 ☐ Yes 2 🗖 🗖 o		dono riioani, oto.	,		hite
5003	E E	Completed by	3   Widowed 4 □ Divorced	Year or Dates:								
2 2	nation and	lete	15. Decedent's Ed (Specify only highest gra	ducation ide completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retir	ipation e during most of	working		Kind of Business/	Industry
with a	th en	d mc	Elementary/Secondary (0-12)	College (1-4or	5+)	1	omemaker			Ot	vn Home	
E POR	ent.	ပိ	17. Father's Name (First, Middle, Last)	1		1		18. Mother's	Name (First, Mi	ddle, Maide	n Sumame)	
land be lental	ked o	To Be	Mathais Franz					Catl	herine	Frei	chman	
Battimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	E III	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Stree	et and Number or	r Rural Route Ni	umber, City	or Town, State, Z	Zip Code)
and 2	er tra		Patricia C. Kupf	Ter/Niece	(F-2 CV C-25	1	Foxview		Glen B	urnie	MD 2106	1
of He	r ite		20a. Method of Disposition  1 Surial 2 Cremation 3 C	Domoval from State	20b. F	Place of Disponentery, crei	sition (Name of matory or other pl	ace) Fol	Date 22 200		ocation - City or I	
Pag nent	ant: I ury o		4 Donation 5 Other (Specific		T:	rinity	Cemeter	у	0 22,200	JO Da.	rcimore	MID CIE
Baltimore, permit. Pages 1 ar Department of Hea	Import any inj once.		21. Signatur O Funeral Service Licer	1800		22	Name and Add	ess of Facility	Funeral i	Home Tr	Υ.	
ш &о.	드루리		124 (7				<u> 1501 East</u>	Fort Ave	Baltimon	<u>e MD 21</u>	230	
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that cause one cause on each l	d the deat line.	h. Do not ent	er the mode of dy	ring, such as care	diac or respirato	ory arrest,		Approximate Interval Between Onset and Death
,	sician	3	Immediate Cause (Final disease or condition	. RESP	IRA	TORY	FAIL	URE				2 days
	edical miner		resulting in death)	Due to (or as					1652043			3-
		- I	Sequentially list conditions,	Due to (or as			EMDOM	ETRIAL	- CAN	NCER		5 days
V B	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (0) as	a conseq	derice or).						
у жесп	al-tra	xai	that initiated events resulting in death) Last	C. Due to (or as	s a conseq	uence of):						
760, cte be executed	ed by the ettending physicien and detached for use as the burial-transIt	call		d.								
68 tificat	g phy as th								100			
Box eath cert	es n	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			⊒Ectopic pregnan				23d. Date of deli	ivery
G te e	ed for	sicia	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4☐Pregnant a			Other (specify)				Month	Day Year
P.O.	by the	by Physician/Med	9 Unknown									
I Records, P.O. Box 68 The law requires that the death certifica	5 0		Part II. Other significant conditions of	contributing to death	but not res	ulting in the u	nderlying cause g	iven in Part I.				the cause of death?
ord requir	been sig	Completed			-				_	1 ☐ Yes	ZLINO 3MPR	obably 4 □Unknown
e e	2 2	nple							- 6	Was an autopsy	prior to d	topsy findings available completion of cause of
# T	pag.	S								es 2 N	death? o 1 ☐ Yes	2□ No
Vita	is certificete ha director, page	Be	25. Was case referred to medical examiner?	Hospital:			!0	26. Place of I	Death (Check o	nly one)		
Phys	두급	5	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Inj		ER/Outpatier 28b. Time of	II 3LI DOA	4 🗀 Nursin			6 ☐Other (Specury occurred	cify)
ding .	After	fo	1 ☑Natural 5 ☐ Pending	(Month, Da	ay Year)	Injury	W	ork? □Yes 2□No	200. Desci	ibe now in	ury occurred	
Division of Vital Records, a or Attending Physician: The law requires tater death.	ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of In	ijury - At h	ome, farm, str	eet, factory, office		28f. Locati	on (Street a	and Number or Ru	ıral Route Number,
Div.	d in b	Certification;	4  Homicide determined	building, e	itc." (Specif	(y)	,,		City o	r Town, Sta	te)	
Hospital	To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Ph	ysician: To the best	t of my kno	owledge, deat	h occurred at the	time, date and pl	ace, and due to	the cause(	s) and manner as	stated.
n 24 i	he Fu	Medical	(Check only 2 Medical Exer	niner: On the basis of and manner s	of examina	ition and/or in	vestigation, in my	opinion, death o	ccurred at the to	me, date ar	nd place, and due	to the cause(s)
To the within	To t	Σ	29b. Signature and title of certifier					nse number			ate signed (Monti	•
)			Klingalnite	or m.s	D.		Rt:	5 001		FEB	RUARY, 18	,2006
i	5		30. Name and address of person who		`.		Print)					
	_		RACHANA M. PALNET		0150		IANOVER	STREET	BALTIM	ORE 1	MARYLAN	ID 21225
	Sta Registr		31. Date filed (Month, Day, Year)	32. <b>33</b> gišt	rars Signa	ature	2					
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cian	1. Decedent's Name (First, Middle, L	•		inoute of		2. Date of Death		3. Time of Death			
lical	Henry L. Gre	eenwell				FEBRUAR	Y 13, 200				
iner	4a. Facility Name (If not institution, g	ive street and number)			Location of Death		4c. County of Death				
	9211 STUART LANE	C	In a think do. ()	CLINTO	N If Under 24 Hrs.	9 Date of Righ	PRINCE C				
l r	5. Social Security Number 215–38–3170  Usual Residence of Decedent	Sex ★ M 2 F 65	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept.5,	Year) 1940 Ca	Birthplace (State or Forei Country) 1vert Cty.M			
tor	10a. State 10b. County		y, Town or Lo linton					10d. Inside City Limi			
Jirec	10e. Street and Number			10f. Zip Code		10	og. Citizen of What	Country?			
ia i	9211 Stuart Lane	e		2073			United S				
by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wi Specify:B1				
Completed	15. Decedent's (Specify only highest of	Education trade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of wor		16b. Kind of Busines	ss/Industry			
E	Elementary/Secondary (0-12)	College (1-40r 5+)	La	borer			Priv	ate			
Be	17. Father's Name (First, Middle, La	st)			18. Mother's Nan	ne (First, Middle, M	Maiden Surname)				
ျှ	Joseph P. Green	well			Helen	M. Buck					
	19a. Informant's Name/Relationship	, ,, ,		,			City or Town, State	a, Zip Code)			
	Randolph Greenw			Gwynn Dai		-					
	20a. Method of Disposition 1	☐Removal from State	emetery, crei	osition (Name of matory or other place	ı		20c. Location - City				
	4 □ Donation 5 □ Other (Spec	and the second control of the second control		Memorial			Suitland,				
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Alexander S. Pope Funeral Homes, P.A.  5538 Marlboro Pike/Forestville, Md. 2										
$\perp$	23a. Part 1. Enter the dispase, or co		b Do set set	5538 Mar	Lboro Pil	e/Forest	ville, Md	Approximate			
	shock, or heart failure. List on	ly one cause on each line.				or respiratory arre	, sst,	Interval Between Onset and Death			
	disease or condition resulting in death)	a. Atheroslcerotic		vascular di	sease			-			
	Commentally list conditions	D									
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42	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):								
42	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	uence of): ancy	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of o	delivery Day Year			
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State of Maryland Department of Health and Mental	nyglerie ) h h c	-0
Certificate of Death	C U U U	U

Patric	ia Anna	ali		iter#23a,27 M	eryFan654	Department of Certificate of		lental Hy	giene 2	06	06245
			1 - State Registrar			Certificate of	Deam		Reg. No.		7.2
	Physici	an	Decedent's Name (First, Middle, La	ast)				2. Date of De Month Februa	Day O	Year	3. Time of Death
	/Medic	al	Patricia Anna 4a. Facility Name (If not institution, gi			4b. City, Town,	or Location of Death	Februa		2006 y of Death	7:20 PM
			Union Hospital			E1kte	on		Ceci	1 Co	ıntv
0	Funeral		Social Security Number 6.		ge (In yrs. last b		If Under 24 Hrs.	B. Date of Bir (Month, Da	th		lace (State or Foreign
2	Director		089-94-2324	1□M 2 <b>X</b> )F	1	Yrs.		Dec. 20,			York
1	2 >		Usual Residence of Decedent  10a. State 10b. County		10c City To	wn or Location				1	0d. Inside City Limits
	Maryland I-1 ehow	_		7		kton					1 ☐ Yes 2 🛣 No
2	9 P P	ecto	Maryland Ceci	· <b>.</b>	151				10g. Citizen of	M/hat Cour	-ta-2
	NIII NIII	ä				10f. Zip Code	21021				·
;	s 1 and 2 should be filed within 72 hours after death with the Maryla If Health and Mental Hygiene. If the m 21 is marked other than "natural", or freme 23a or 28a-1 ehov other treumatic event, the Madical Examinar must be notified at	Funeral Directo	102 Willow Drive	12. Was Decedent	Sver in II S		21921	ecify Yes or No		ed Sta	
	ttem trem	nu.	11. Marital Status  1 Never Married 2 Married	Armed Forces	?	13. Was Decedent of If Yes, specify Cul			Bla	ck, White,	
999	l', or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	2.0	1 X Yes 2 ☐ No			Speci	<sup>fy:</sup> Hisp	panic
Maryland 21215-0036	atura a	ed	15. Decedent's E	ducation		a. Decedent's Usual Occu	ination	enican	16b. Kind of E	Jusiness/Inc	dustry
57	n na	Completed	(Specify only highest gi	rade completed)  College (1-4or	5+)	(Give kind of work done life. DO NOT use retir	e during most of work ed)	ing	Not Se	elf Su	apporting
212	yiene. r than the Mar	E	0	College (1-40)	5+)	Dependent					
9	E Hyg	Be C	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle	Maiden Suma	me)	
<u>a</u>	ic d be	To B	Jose Garcia				Tanya Ma	rie Dor	nato		
<u>^</u>	Shou Ind N	_	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Address (Stree	at and Number or Rui	al Route Numb	er, City or Town	, State, Zip	Code)
ž	27 14 2 17 14 18 18 18 18 18 18 18 18 18 18 18 18 18		Tanya Marie Dona	to / Mothe	er 1	02 Willow D	rive, Elkt	on, Mar	yland 2	21921	
Baltimore,	permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other treumatic event, tha Mandoce.	1. 12	20a. Method of Disposition		20b. Place	of Disposition (Name of ery, crematory or other pla	ace)	Date	20c. Location	- City or To	own, State
ê,	ent o ent o ry or		1  Burial 2 □ Cremation 3  4 □ Donation 5,□ Other (Spec			ess Hills Ce		5/06	Brookly	m, Ne	w York
重	e injurie	o h	21. Si mallus of Fymeral Service Lice		1 2 2		ress of Facility Fur	praria	Hermano	)S	
ñ	Depar Impo any ir		1-SITUMOO		M01113		on Street,				11208
			23a. Part1. Enter the disease, or con	nplications that cause	d the death. Do						Approximate Interval Between
	lhusisian		shock, or heart failure. List ont Immediate Cause (Final			1 1 .1 . 1 .	<b>.</b>				Onset and Death
	hysician /Medical		disease or condition resulting in death)		nexplaine s a consequence	d death in chi	Idhood				·
	Examiner			046 10 (01 43	3 4 001304001101	3 017.					
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or as	s a consequence	a of):					
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
<u>.</u>	be executed ician and burial-transit	EXB	resulting in death) Last	C. Due to (or as	s a consequence	e of):					
)92	ysicia ysicia	cai		d							
	micat g phy es the	edi							1	Ti.	
Вох	eath certificate t ettending physi I for use es the b	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		·			23d. Da	ate of delive	ery
m	death e ette d for	icia	in the past 12 months?	4☐Pregnant a	2 🗌 Fetal deat at time of death	th 3 ☐Ectopic pregnan 5 ☐ Other (specify)			М	onth	Day Year
0	iaw requires that the death certilics as been signed by the ettending ph 2 should be detached for use es t	Physician/Med	9 □ Unknown	9□ Unknown							
٠,	w requires that been signed b should be deta	by P	Part II. Other significant conditions	contributing to death I	but not resulting	in the underlying cause g	iven in Part I.	23e. Did 1	obacco use cor	tribute to th	he cause of death?
Ę.	quire n sig uld b	P						1 🗆	Yes 2. ☐ No	3 Prob	ably 4 Unknown
Division of Vital Records,	w respectively	Completed						24a. Was	an 24b.	Were auto	psy findings available
æ	o ← ®	Ë							rmed?	death?	mpletion of cause of 2□ No
ta (	ilcian: Th certificate rector, pag	O	25. Was case referred to medical	2.500		777.050	26. Place of Deal	128 Yes	-	1/1.51 63	20140
<b>&gt;</b>	Physician: rthis certific ral director,	To B	examiner? 1 ဩrYes 2 ☐ No	Hospital: 1 ☐ Inpati	ient 2 CNER/C	Outpatient 3 DOA	ther		dence 6 □Ot	her (Specif	<i>ا</i> لا
ō	y Phys ar this eral dir		27. Manner of Death	28a. Date of Inj (Month, Da		Time of 28c. Inj			how injury occu		
lo :	Attending Fr death. sctor: After by the funer	it o	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati		ay rear)	Injury W	ork/ ☐Yes 2 ☐No				
S	Attendir death.	<u>2</u>	3 ☐ Suicide 6 ☐ Could not	d 28e. Place of In	njury - At home,	farm, street, factory, office	9			ber or Rura	al Route Number,
D.	To the Hoepital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	4  Homicide determine	building, e	itc. (Specify)			City or To	wn, state)		
	epita nours nere			Physician: To the best	t of my knowled	ge, death occurred at the	time, date and place,	and due to the	cause(s) and m	anner as s	tated.
	Ho Ho	Medical	(Check only 2 Medical Expone)	aminer: On the basis of and manner s		and/or investigation, in my	opinion, death occur	red at the time,	date and place	, and due to	o the cause(s)
_	To th Withir To th Somp	M	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date sign	ed (Month,	Day, Year)
			> aus 2			OCM	Ε.		Febru	ary 1	9, 2006
			30. Name and address of person wh	o completed cause of	death (Item 23a		111				7.5
			AMA RUBI	0 MD		111 P	enn Street	Baltin	nore, Ma	ırylar	nd 21201

State Registrar

mth, Day, Year)

MAR 0 2 2006

MAR 0 2 2006 31. Date filed (Month, Day, Year)

		1	For State Registrar	State of Maryland /		artment of H		nd Mer		ene 2.006	06246
			Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		LAURA	HAFELE					2 0	2001	
	Examin		a. Fecility Name (If not institution, give st	eet and number)		4b. City, Town, or	Location of I	Death		4c. County of De	_
			Howard County Gene			Colu		Ure I e	Date of Disk	Howa	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1	7. Age (In yrs. last	Vrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day, Y	907 Po	Birthplace (State or Foreign Country) 1and
	D.	<b>⊢</b>	Usual Residence of Decedent	10c. City, To	oum or Lo	cetion					10d. Inside City Limits
	anylar show		10a. State 10b. County  Maryland Baltimo		OWIT OF EC		nsvi11	le			1 ☐ Yes 2 XNo
	Ne M	ecto	Maryland Baltimo	LC		10f. Zip Code			100	. Citizen of What	Country?
	with with		39 Nunnery Lane				1228			US	A
	ms 23	lera		2. Was Decedent Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba		n? (Specify	y Yes or No-		merican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic evant, the Medical Evant	Completed by Funeral Director	1 Never Married 2 Married 3 Nover Married 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		irYes, speciny Cuba 1 □ Yes 2 ŪXNo		Fuelto Aic	an, etc.)	Specify:	White
Maryland 21215-0036	2 hours	ted	15. Decedent's Educa	ution 1	6a. Dece	dent's Usual Occupa	ation	of wasting	16	6b. Kind of Busine	
15	n n	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	iuring most c )	or working			
212	e filed within al Hygiene. other than "	E C	8		H	omemaker				Own Ho	me
g	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother			uiden Sumame)	
yla	should be ind Mental s marked o umatic eve	ပို	Alexander Br					Anto		hojnacki	
Nar	2 sh and Is m raum		19a. Informant's Name/Relationship (Typ			ng Address (Street a				by, MD $21$	
6,1	1 and 1ealth am 27 ther tr		Carol M. Scully/Da	ugnter 20b. Place		Dower Consistion (Name of matory or other place		Date		oc. Location - City	
Jor	ages nt of H : If its		1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State Crest	etery, cre :1awn	matory or other place Memorial	1	2/2/0	. N	Iarriotts	sville, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signaturepof Funeral Service-License</li> </ul>			2. Name and Addres		3/3/0 MacN	V	eral Hom	
Ba	permi Depar Impo any ir		Edward A. Arego			301 Frede					
			t,	Approximate Interval Between							
	Pnysician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Atheroscle	no lu	c Card	10 vas	ala	1 Dix	care	Onset and Death
	/Medical		resulting in death)	Atheroscle  Due to (or as a consequer  Consense.	nce of):	, ,					Univ. 10
В	Examiner		Sequentially list conditions, b.	Due to (or a a consequen	T	east t	alli	ne			
7	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	100 01).						V.
Λ.	be executed siclan and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a consequen	nce of):						
8760,	ate be e hysiclar the buri		L <sub>d</sub>								
9	tificat ng phy as th	Physician/Medical	IF FENALE.								
Вох	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnance 1 Live birth 2 Fetal de	ath 3	⊒Ectopic pregnancy	,			23d. Date of Month	delivery Day Year
	e dea the at hed fo	sici	1 Pes 2 No 9 Unknown	4□Pregnant at time of deat 9□ Unknown	h 51	Other (specify)					
P.0	res that the de signed by the a be detached t		Part II. Other significant conditions con	ributing to death but not resulti	ng in the i	ınderlying cause gıv	en in Part I.		23e. Did toba	acco use contribut	e to the cause of death?
Records,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	d by							1 🗆 Yes	2 0 3	Probably 4 Unknown
COL	w require been sign	Completed							24a. Was an	24b. Were	autopsy findings available to completion of cause of
Re	The lav te has age 2	то							autopsy pertorm	ed? deat	
Vital	ysician: The is certificate hi director, page	0	25. Was case referred to medical				26. Place	of Death (	Check only one	)	
<b>\</b>	Physici this ce al direc	To B	examiner? 1 ☐ Yes 2 No	ospital: 1XInpatient 2□EF	VOutpatie		4 🗆 1401			ice 6 Other (5	Specify)
n of	Jing Ph J. After th funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 21 (Month, Day Year)	8b. Time Injury	Wor			d. Describe hov	v injury occurred	
Sio	Attending in death.	cati	2 Accident investigation 3 Suicide 6 Could not be	CO. Div. Military Alban			Yes 2□N		f Location /Str	et and Number o	r Rural Route Number,
Division	after of Direct	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, iarm, s	reet, factory, office		20	City or Town,		, ribrar rieste rramber,
	spital hours ineral y filled	aic	29a. Certifier 1 Certifying Phys	ician: To the best of my knowle	edge, dea	th occurred at the til	me, date and	place, and	d due to the car	use(s) and manne	r as stated.
	To the Hospital or Attending Phwilin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one)	er: On the basis of examination and manner stated.	ii ariwor i	29c. Licens				d. Date signed (M	
<b>\</b>	To To	2	29b. Signature and title of certifier	( ) Cum		7) 2	c 6 li	1	F	hrears	28 200h
	_		30. Name and address of person who co	mpleted cause of death /Itom 3	(Type	Print)	0 0 4	1		( )) way	44
	5		RAMESH SABA	P的H 201-10			Neck	k Kac	red B	altimor	28 2006 e Mayland 2121
	Sta Regist	ate rar	31. Date filed (Month, Ray Year) 2 20	32. Aegistrar's Signatu	(O						
		100			4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MARC 7:12 AM FOWARY 2006 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VAmc NIA BACTIMORE DALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 2 M 2 □ F Months Days Hours 78 Yrs. 227. 28.5262 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hyglene. ant: If item 27 Is marked other than "natural", or Items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County other traumatic avent, the Medical Erar, it at mast be notified at MD Baltimore 1 XYes 2 No To Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Caroline Street 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Poplar Manor College (1-4or 5+) Elementary/Secondary (0 Maintenance Supervisor 9th grade Nursina Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Humes Fure Hami 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Street Balto. MD 21213 721 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State DWING Mills MD Department of Important: If any injury or soce. Garrison 03.09.06 Forest • 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Valuation C. Green
4406 York Roa C. Greene Funeral Sowices York Road Balto. MD 21212 21. Signature of Funeral Service Licensee lun w. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LMONA Pnysician U disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 20 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death, To tha Funaral Diractor: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number MID 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (North Day)

2006

1000 Co

32. Registrar's Signatures

			State of Maryland /1 1- State Amend Item/20b per FH G853 3/9	Department of Health and Mental Hygiene 9.006tiffsate of Death Reg. No. 0624	}								
\$ 3.3 \$ 3.5 \$ 3.5	Physici /Medio		1. Decedent's Nam <i>e (First, Middle, Last)</i> Mary E. Hensley	2. Date of Death Month Day Year Feb 27, 2006  3. Time of Death 1500									
	Examin		4a. Facility Name (If not institution, give street and number) 2710 Pinewood Drive	4b. City, Town, or Location of Death  Waldorf  4c. County of Death  Charles County									
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 577 56 5194 1□ M 2∏ F 84	rithday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Ray 1, 1921 9. Birthplace (State or Formulation) May 1, 1921 9. Birthplace (State or Formulation) May 1, 1921 Clinton, MD	reign								
	yland how			wn or Location 10d. Inside City Li	mits								
	8a-fs	Director	Maryland Charles	Waldorf 1□Yes 2√X	XNo								
	23a or 2		10e. Street and Number 2710 Pinewood Drive	101. Zip Code 10g. Citizen of What Country? United States									
980	d within 72 hours after death with the Maryland Jione. r than "natural", or Itama 23a or 28a-f show the Medical Exatular mether rediffed at	by Funerai	11. Marital Status  1 Never Married 2 Marned  1 Never Married 2 Marned  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1☐ Yes ★★No Specify:  14. Race - American Indian, Black, White, etc.  Specify: White									
Maryland 21215-0036	in 72 ho n "natur Medicul	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired)  16b. Kind of Business/Industry									
212		Com	8th H	Homemaker Own Home									
and	ag la b	Be	17. Father's Name (First, Middle, Last)  John Gue	18. Mother's Name (First, Middle, Maiden Sumame)  Daisy Mae Johnson									
aryk	2 should be and Menta le marked sumatic ev	2		b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	nd 2 lith a 27 lc			2710 Pinewood Drive, Waldorf, Maryland 20601									
Baltimore,			TEX BUILDI 2 COSTILLATION 3 CHARLOVAL HOLD STATE	of Disposition (Name of ery, crematory or other place) 3/6/06 Cheltenham, Maryland	d								
Balt	permit. Page Department of Important: If any injury or 2008.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Lee Funeral Home, 6633 Old Alexandria Ferry Road, Clinton, MD 20735									
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximation										
	Physician /Medical		mmediate Cause (Final disease or condition a Congestive Heart Failure										
6 ,	Examiner		Due to (or as Aconsequence	Depletion									
	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	+ Peritonenl Effusion									
	axecute n and al-tran	Examine	that initiated events resulting in death) Last  c.   VIAII 4 DA D  Due to (or as consequence										
68760,	ficate be executed physician and is the burial-transit	edical	d										
		/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery									
P.O. Box	the death y the atter sched for u	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	th 3 Ectopic pregnancy Month Day Year 5 Other (specify)									
	law requires that the death cert as been signed by the attending 2 should be detached for use a	þ	Part II. Other significant conditions contributing to death but not resulting  Diabetes Mell Itas	in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death									
of Vital Records,	operformed? death?												
/ital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
<b>∫</b>	Phys this ral di	٠ <u>.</u>	1   Yes 2 No										
	ing After une	ation		Time of Injury M 28c. Injury at Work?  M 28d. Describe how injury occurred									
Division	al or Attend s after death I Director: , d in by the f	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f. building, etc. (Specify)	farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	Hospitu 4 hours Funera tely fille	edical C	(Chack only 3 Medical Evaminary On the basis of avamination as	ga, death occurred at the time, date and place, and due to the cause(s) and makes as stated, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) 3-1-0	6								
	10	18	30. Name and address of person who completed cause of death (Item 23a) William Jones, M.D.	(Type, Print) Shady Side Rd. 20764									
	Sta Regist		31. Date filed (Month, Day, Year) 32. Signstrar's Signature MAR 0 2 2006	29c. License number 29d. Date signed (Month, Day, Year) 3-1-0 (Type, Print) Shady Side Rd. 20764									
- 4	7.2		WAR U Z ZUUS   Flores As										

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	1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 6								06249			
Planaiaia	Decedent's Name (First, Middle, Last)								Year ,	3. Time of Death		
Physicia /Medic			KENNETH RA	Y HAR			March		2106	8:45 AM		
Examin	er	4a. Facility Name (If not institution, give str	101		_	r Location of Death			inty of Death Bal Fimon			
Funeral		Saint Joseph Medic 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birti (Month, Day	1		ace (State or Foreign		
Funeral Director			<sup>M 2□F</sup> 63	Yrs.	Months Days	Hours Min.	8/18/	y, Year) 1942	ALA	BAMA		
D .		Usual Residence of Decedent  10a. State 10b. County	10c Cit	ty, Town or L	ocation				10	d. Inside City Limits		
Aarylan Febow	ō	MD CARROLL		•	NSTER				'	1X Yes 2 □ No		
the h	rect	10e, Street and Number	1 ,,	<u> </u>	10f. Zip Code			10g. Citizen	of What Count	ry?		
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene than "neturel", or items 23s or 28s-f show ent, the Medical Examination must be notified at	Funeral Director	30 FITZHUGH AVE			2115	7		USA				
ems (	ner	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. F	Race - America Black, White, e			
s afte	by F.	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give		1 □ Yes 2 No	Specify:			ecity: WHI			
tural E		15. Decedent's Educa	Year or Dates:VIET	16a. Dece	dent's Usual Occup	pation			f Business/Ind			
hin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor d)	king					
ad wit	Сош	12	2		SOLDIE				TARY			
be filed that Hyg of other	Be	17. Father's Name (First, Middle, Last)		ממענו		18. Mother's Nam				D		
d 2 should th and Mer 7 is marke traumatic	2	DAI  19a. Informant's Name/Relationship (Type			ng Address (Street		EN IRE					
so 1 and 2 should be filed with of Health and Mental Hygiene (I flem 27 is marked other than ir other traumatic event, than		JOYCE F. HARP	- WIFE	I	FITZHUGH			-				
of Healt Item 2		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place		Date		on - City or To			
Pages nent of int: If It		X Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	MEM.GA	1	/4/06	FINK	SBURG,	MD		
permit. Pag Depertment Important: I eny Injury o once.		2 . Signaturero Funeral Service Licensee		2	2. Name and Addre	ss of Facility FI	ETCHER	FUNE	RAL H	OME		
80559					54 E. M		•		R, MD			
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.		/	1 1		rest,		Approximate Interval Between Onset and Death		
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	onaly	artery	1 disea	se	-				
Examiner			M	VOCASI	tial int	farction				5 days		
/ 7 =	ner	resulting in death)  Due to (or as a consequence of):  Myo (ardial in farcfion  Due to (or as a consequence of):  Myo (ardial in farcfion  Due to (or as a consequence of):  Cause (Disease or injury that initiated events  Car diowy pathy										
and transi	Examiner	that initiated events c. Car drowy opathy										
be executed sicien and burial-transit	cal Ex	Due to (or as a consequence of):										
3 7 6		<b>d</b> .										
The law requires that the death certification because the properties are the attending phage 2 should be deteched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregna		<b>7</b>			23d.	Date of delive	ту		
death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		□Ectopic pregnancy □ Other (specify) _	у			Month	Day Year		
et the de 1 by the a	Phys	9 Unknown		41 1 1			80. 014					
signed I be det	<u>۾</u>	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.							cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown			
w requir been si should	Completed	Nich Le						24a, Was an 24b. Were autopsy findings available				
The lav ate hes page 2	mc	Diapea	10.00				autop	rmed?	prior to con death?	pletion of cause of		
ilclen: Th certificate rector, pag	a l	25. Was case referred to medical	tension			26. Place of Dea	1 ☐ Yes		1 🗆 Yes	212 No		
ysich iis cer direct	ToB	examiner?	spital: 1 Inpatient 2 I	ER/Outpatie	nt 3 DOA Oth	or.	ome 5 Resid		Other (Specify	)		
ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor	rk?	28d. Describe h	now injury oc	curred			
ttendi Jeath. tor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	OD - Disco of lains. Ash			Yes 2 □ No	294 Leastion /6	Strong and Mr	mbos as Gusa	Dougla Mumban		
or All or All of All or	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	fy)	reet, factory, office		28f. Location (S City or Tox		imber or Hurai	noute Number,		
To the Hospital or Attending Physicien: within 24 hours alter death To the Funeral Director: After this certifica completely filled in by the funeral director,	1	29a. Certifier 1 Certifying Physic	cian: To the best of my kno	owledge, dear	th occurred at the tir	me, date and place	, and due to the	cause(s) and	manner as sta	ated.		
he Ho n 24 h he Fu pletely	Medical	(Check only 2 Medical Examine one)	er: On the basis of examina and manner stated.	ation and/or in	ivestigation, in my o	opinion, death occu	rred at the time,	date and plac	ce, and due to	the cause(s)		
To t To t	Σ	29b. Signature and title of certifier	#	Λ	29c. Licens				gned (Month, L	•		
<b>1</b>		r Kerry for		rry Pr	ewill ms	D 5732	9	M	arch 1	,2006		
411		30. Name and address of person who com	apleted cause of death (Iter	n 23a) (Type #103	Print) Towns	NERRY SOU MI	2120	24				
Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signa		M 8	,						
Registr		MAR 0 2 2006	Minner of B	LICAN								

ORIGINAL

			State of Maryland / Depa	rtment of Health and M	*	•	00050
_				tificate of Death	Reg.	No: UUU	06250
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death     Month	Dav Year	3. Time of Death
	/Medic		Jean Marie Healey		Month 02 2	2006 2006	4:45pm <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
			Gilchrist Hospice  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson If Under 1 Year   If Under 24 Hrs.		Baltimore	
3	Funeral Director		5. Social Security Number   6. Sex   1 □ M 2 🖔 F   7. Age (In yrs. last birthday)   7. Age (In yr	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 09-15-193	ar) 9. Birthp	place (State or Foreign
2			Usual Residence of Decedent		09-13-193	oz viitar	io, Canada
7	ylanc		10a. State 10b. County 10c. City, Town or Loc	ation		1	0d. Inside City Limits
1	Ma-1-	ctor	Maryland Baltimore				1 ☐ Yes 2 X No
	or 28	Oire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coul	ntry?
-06	death with the Maryland me 23a or 28a-f show rmst be notified at	Funeral Director	8620 Kelso Drive, Apt. C209	21221	U.S	.A.	
1	ar de:	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 242140	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
35%	s afte	by F	If Yes, Give	☐ Yes 2⊡ No Specify:			White
1,00	72 hours after death with the Marylar 72 hours after death with the Marylar "naturel", or itame 23a or 28a-1 show rdical Examinar must be notified at	ed t	102.0.00	ent's Usual Occupation	16h	Kind of Business/In	
L. 17	n n	plet	(Specify only highest grade completed) (Give k	ind of work done during most of worki O NOT use retired)	ng	. Kind of Business/in	dustry
25	s within liene. The Med	шо	Elementary/Secondary (0·12) College (1·4or 5+) 12th Secre			inancial	
2 3	e filed Il Hygi other	e C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	len Sumame)	
3	Mental Mental rked o	To Be Completed	John James Kasubeck	Geneviev	e Irene		
Maryland 21215-0036	sho and l		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rura	I Route Number, Cit	y or Town, State, Zip	Code)
07	and and m 27			Kirkwood Shop Rd.	and the same of th	all, MD	21161
0	Tof H if ital		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition cametary, cremitally	ition (Name of atory or other place)		Location - City or To	own, State
leale	Pag Imen Iant: jury		4 □Donation 5 □Other (Specify) Gardens of	Faith Cem. 03-0	01-06 B	alto., MD	
7	permit. Pages 1 and 2 should be filled within Department of Health and Martal Hygiene. Important: if itam 27 is marked other than any injury or other traumatic event, the Maganee.		M 04002/	Name and Address of Facility		ippel Fun	
	4 40.280			15 Belair Road, B		MD 2120	
			23a. Part Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.	r the mode or dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	/ LCUER			years
	Examiner		Due to (or as a consequence of):	ie diseuse			0
	,	er	Sequentially list conditions b. Due to (or as a consequence of):	ic algebra			years
	d d ansit	Examiner	Sequentially list panditions if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				v
Ċ	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):				=
760	2 2 2	Icai	d				
89	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	Med	IF FEMALE:				
Box	ath ce ttendi	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delive	,
-	the a	Physician/M	1   Yes 2   Yoo 9   Unknown 9   Unknown	Other (specify)		Month	Day Year
O d	that the de the by the a		Part II. Other significant conditions contributing to death but not resulting in the unc	ferlying cause given in Part I	23a Did tohaco	o use contribute to the	o cause of death?
4	signe d be	Completed by	A lety wellity renal	Lacluse	1 Tes		ably 4 □Unknown
Š	w requir been si should	ete				/	
ď	sician: The law certilicate has t irector, page 2 s	m		-	24a. Was an autopsy performed?	prior to cor death?	psy findings available apletion of cause of
7	n: Ti flicate or, pa	e Co	25. Was case referred to medical		1 ☐ Yes 2 💯 1	No 1 ☐ Yes	2 No
Š	Physician: this certifica	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient	26. Place of Death  3 □ DOA Other: 4 □ Nursing Hor	(Check only one) ne 5 ☐ Residence	c 10000 (0000)	1/2000
Ď	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 2	28d. Describe how in		Hospice
j	Attending I r death. ector: After by the funer	atlo	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records	r Atte er de recto by th	ti ti	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura	l Route Number,
	ital or rs after ai Dir led in	Cer				110/	
	Hospital	cai	29a. Certifier (Check only and a continuous)  1 Cartifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation.	occurred at the time, date and place, a	and due to the cause	(s) and manner as st	ated, the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	and mariner stated.				
	5 × 6 × 6	_	250. Signature and illier certifier	29C. License number	290.	Date signed (Month,	26.200/
			I Trong way	725 203	1-e	DIONT -	1-006
	3		30. Name and address of person why completed cause 1 seth (Item 23a) (Type, Pi	29c. License number  25 205  Print Bole St. Bo	lto md	21204	
	Sta	te_	31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAR 0.2. 2000	and d			
	Registr		MAR 0 2 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per fh e853 3-21-06 vt
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Zoole AMILTON 25 /Medical 4a. Facility Name (If not institution, give street 4c. County of Death Examiner COLUMBIA COUNTY HOWARD Birthplace (State or Foreign Country) **Funeral** Hours Months Min Days 219 32-3173 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No HOWARD EWICOTT Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MONTGOME CO 238 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itema 14. Race - American Indian, 11 Marital Status Black, White, etc. 1952 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 9560 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Bendix Elementary/Secondary (0-12) College (1-4or 5+) Tech Writer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Pages 1 and 2 should be Hamilton Hains Harriet Govane Ridout Ligon 19a Informant's Name/Belationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 8170 Old Montgomery Rd. Ellicott City, Maryland 21043 Mrs. Charlotte Hains Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 Cremation 3 Removal from State permit. Page Department of Important: If any njury or once. tion 5 Other (Speg 03/01/2006 Ellicott City, MD St. John's Cemetery re of Friheral Service Signat ensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between nediate Cause (Final ease or condition sulting in death) **Physician** /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s efter death 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours of To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylan		artment of H rtificate of I		Mental Hy	giene Reg. No.	06	06252	
	Physici	an	1. Decedent's Name (First, Middle, Las	HANVEY				2. Date of De Month		Year	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Dea	Feb	4c. Co	unty of Death		
			University of Man  5. Social Security Number  6. Se		Center	BALT If Under 1 Year	1 MORE	8. Date of Bir	th	Q Rimb	nplace (State or Foreign	
	Funeral Director		229–28–0776	⊒м 2 <b>В</b> 7 79	Yrs.	Months Days	Hours Min		1926	Vir	ginia	
altimore, Maryland 21215-0036	yland		Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo						10d. Inside City Limits	
	he Mar 28a-f el		VA New Ker	it N	lew Ken	t -Quinto	on 			(100) - 2	1 □Yes 2 ☑ No	
	th with 1 23a or 2	ai Dir	10e. Street and Number 11121 Cosby Mil	ll Road		10f. Zip Code 2314	41			i of What Coi USA	untry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or items 23s or 28s-f show any Injury or other traumatic event, the Mudical Exercipes rust be notified at ance.	To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Amer Black, White ecify: Wh		
	within 72 ho ene. than "netu he Mudical		15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	6a. Decedent's Usual Occupation (Give kind of work done during most of working (life. DO NOT use retired)  Packer			16b. Kind of Bus Pepsi-C Bottlin			
	uld be filed Aental Hygi rked other tic event, t		17. Father's Name (First, Middle, Last) Wally Lee Pars	Ley	I			me (First, Middle sey Rich				
	and 2 shousalth and N n 27 fs ma		19a. Informant's Name/Relationship (7)			E.Baltir						
	Pages 1 ment of He ant: if Iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🎾 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, cren	sition (Name of natory or other place Memorial I	L COO			ion - City or 1 <b>umie,</b> M		
Ball	permit. Depert Import any In		21. Signature of Funeral Service Licens	599	22	Name and Address Charles L. 1501 Fast	Stevens	Funeral H	ame Inc	ń		
7			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the deat one cause on each line.	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sepsis  Due to (or as a conseq	e to (or as a consequence of):							
į,	Examiner	_	Sequentially list conditions,	b. Myocardial infarction 1 week						1 week		
J	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							1 week		
Division of Vital Records, P.O. Box	ficate be executed physician and is the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a consequence of):  d. Out C ps. dount Y S M						2 weeks		
	the death certific y the attending p iched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3□	Ectopic pregnancy			23d	Date of deline	very Day Year	
	w requires that the de been signed by the a should be detached f	Certification; To Be Completed by PI	eart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								ontribute to the cause of death?  3 Probably 4 Unknown	
	The law re ate has bed page 2 sho							24a. Was auto perto 1 \( \text{Yes}		4b. Were aut prior to c death? 1  Yes	opsy findings available ompletion of cause of	
	sician: certific lirector,		25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Minpatient 2	ER/Outpatien	· 3□ DOA Othe	00	ath (Check only o		Other (C	4.)	
	ing Phy After this Joeral c		27. Manner of Death 1 ★ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	/ al k?	dome 5 Resi			ny)	
	ul or Attending Physician: The lavalete death. after death. Director: After this certificate has		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stro		Yes 2 No	28f. Location (. City or To	Street and N wn, State)	umber or Rui	ral Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical C	29a. Certifier 1. Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time vestigation, in my op	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)	
	To the Within To the comp	Me	29b. Signature and title of certifier	192 to	17711	29c. License	1854	6	29d. Date si	gned (Month	Day, Year)	
	6		30. Name and address of person who c	ompleted cause of death (Item 175, 22 So	1 23a) (Type,	Print)	t Ro	1.tima-	reb	11	1261	
	Sta	- 2	31. Date filed (Month, Day, rear)	32. Augistrar's Signa			, cu	1111076	1111		, v. v /	
- 7	Registr	धा	MAR 0 2 20	Ub Luch Pages	J. De	BARL!						

			1 - For State Registrer	State of Marylant		cate of Deati		Reg. No.
F	Physici		1. Decedent's Name (First, Middle, Last)	Hendric K			2. Date of De Month	
	/Medic Examin Funeral Director		5. Social Security Number 6. Sex	ford Nursin	G ast birthday) If L	City, Town, or Location	or Death  Or Ce  or 24 Hrs.  Min.  B. Date of Bir (Month, Da	4c. County of Death  N / A  9. Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent  10a. State 10b. County		, Town or Location	1	NOV • 4	4,1923 VIRGINIA
	he Mary 28a-1 sh cuilled	Director	MD . N/A	ВА	LTIMORI			1 ☐ Yes 2 ☐ No X
	23a or	rai Dir	921 N. PATTERSO			f. Zip Code 2120		10g. Citizen of What Country? U.S.A.
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-1 show event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes	Decedent of Hispanic Co. specify Cuban, Mexicoles 2 No Specify	rigin? (Specify Yes or No an, Puerto Rican, etc.) y:	14. Race - American Indian, Black, White, etc.  Specify: BLACK
215-0036	n 72 ho "natura edical I	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's (Give kind of life. DO No	Usual Occupation of work done during mo	ost of working	16b. Kind of Business/Industry
7	ygiene. her than it, the M		Elementary/Secondary (0·12) 8TH	College (1-4or 5+)	COOK			SHERTON INN
Maryland	e d a be	To Be	17. Father's Name (First, Middle, Last)  JAMES MAYO				her's Name <i>(First, Middl</i> e LUCINDY HE	ŕ
Mar	2 2 2 3		19a. Informant's Name/Relationship (Type					er, City or Town, State, Zip Code)
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		DORTHEA HENDRIC  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)  Signature of Funeral Service License	20b. Place	RTSON F 22. Nan	(Name of or other place) MA COREST VE	T. CEMETERY	20c. Location - City or Town, State OWINGS MILLS, MD,
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence)	ence of):	mode of dying, such a	s cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
09/90	rtificate be executed ng physician and i as the burial-transit	Medical Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	on M	D		
O. Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ac. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □Ector	pic pregnancy or (specify)	72	23d. Date of delivery Month Day Year
cords, r	w requires that the been signed by th should be detache	by	Part II. Other significant conditions conf	tributing to death but not resul	lting in the underly	ing cause given in Part		robacco use contribute to the cause of death?  Yes 2 \( \text{No} \) 3 \( \text{Probably} \) Probably
vital necol	The law ate has b page 2 sl	e Completed	25. Was case referred termedical			oc Dis	1 ☐ Yes	psy prior to completion of cause of death? 2 № No 1 ☐ Yes 2 ☐ No
	ysicia s cert direct	0 8	examiner?	ospital:	R/Outpatient 3[	Other	ursing Home 5 Resi	dence 6 □Other (Specify)
on or ing Phy After this uneral d		ıtion; T	27. Manual of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe	how injury occurred
UIVISION	I or Attend after death Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, street, fa	ctory, office	28f. Location ( City or To	Street and Number or Rural Route Number, wn, State)
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	ician: To the best of my know er: On the basis of examinate and manner stated.	rledge, death occu on and/or investig	rred at the time, date a ation, in my opinion, de	and place, and due to the ath occurred at the time,	cause(s) and manner as stated, date and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (Morth, Day, Year)
			Voiv MD			0577	C-1	0/28/00

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 0 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nonandu Uman MD 2 Manhet IC - Aurdalh - MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician BEVERLY ANN IVEY** 2344 Feb 21, 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL **ABREDEEN HARFORD** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 220-64-7206 Director Jan 31, 1955 N.C Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location worde. 10d. Inside City Limits rthen "natural", or Items 23a or 28a-f ehov the Madical Examiner must be notified at MD. **HARFORD EDGEWOOD** 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 640 HARRPARK COURT 21040 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2 □XNo 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XVo Specify ģ Specify Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other then **PLASTIC** MACHINE OPERATOR 3 Department of Health and Mental Hyg Important: If Itam 27 Is marked other eny Injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental JIMMY GREEN LENA MAE CAVER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT IVEY Husband 640 HARRPARK COURT EDEGEWOOD, MARYALND 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State 02/27/06 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) BAYVIEW CREMAYORY 21. Signature of Funeral Pervice Licens 22. Name and Address of Facility Miller"s Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 23a. Part 1. Enter the disease, or complications that caused the death, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical ettending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | ed by the e signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. <u>۾</u> should t 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificete has autopsy performed? res 20 No 2 □ No 1 Tes 1 Tyes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Yes 2 🔀 No ဥ 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After t Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO15448 Men Name and address of person who completed cause of d∞th (Item 23a) (Type, Print)
SRENDRA KUMAR MILAK 200 N.UNION AVEVUE HARFORD, MARYLAND 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State of	Marylan	-	artment rtificate					giene Reg. No.	006	(	062	56
€.	Div. state		1. Decedent's Nam	ne (First, Middle,	Last)				./	,		Date of Dea	ath Day	Ye	ar	3. Time o	of Death
	Physici /Medic	_	Kobert	-					Ker	rler		ebruary	26		06	12:53	5 AM
	Examin	_	4a. Facility Name	(If not institution,	give street and num	ber)		4b. City,	Town, or	Location	of Death	t	4c. (	County of I	Death		
· e		2	The Joh.	NE Hopk	1/0-7	6/	1 binb d 1	Bal's	TIME	If Under	24 450	Date of Bird			D: 4	10:	
TEN	Funeral Director	0	5. Social Security   212-60-3		6. Sex 1√2,M 2□ F	7. Age (In yrs. 55	iast birtnoay) Yrs.	Months	Days	Hours	Min.	Date of Birt (Month, Day OV • 22	n y, Ye <i>ar)</i> ) 1.0	9.50 Ma	Coun	ace (State try)	or Foreign
Ç.			Usual Residence					1			TA	OV. 22	- 9 1 2	750 110	ıry.	Land	
	how		10a, State	10b. County		10c. Cit	y, Town or Lo	cation							11	Od. Inside C	
	Ba-1s	cto	MD	N/A		Ba1	timore									1 1x1Yes	s 2 □ No
	th with th	al Director	10e. Street and Nu 1255 Hav		Road			10f. Zip 212					10g. Citiz J • S • <i>A</i>	en of Wha	t Coun	try?	
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or Itams 23s or 28s-1 show event, the Modical Externity in all be notified at	by Funeral	11. Marital Status 1 □ Never Mar 3 □ Widowed	ried 2 Marrie	12. Was Dece Armed For 1XXYes If Yes, Give Year or Da	ces? 2 □ No ∍		Was Deced If Yes, spec	ify Cubai	spanic Ori n, Mexicar Specify:	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)		4. Race - A Black, N Specify:	Vhite,	etc.	
5-0	72 ho	Completed	(Spe	15. Decedent's	s Education grade completed)		(Give	dent's Usua kind of wor	k done d	luring mos	t of working		16b. Kin	d of Busin	ess/Inc	lustry	
121	d 2 should be filed withIn h and Mental Hygiene. 7 Is marked other than "traumatic event, tre Men	d m	Elementary/Sec 12	ondary (0-12)	College (1-	4or 5+)	Ceram	DO NOT us			cian		Mate	erial	2		
42	Hygie ther t	e Co	17. Father's Name		ast)		Ceran	тс па	10		er's Name (F	irst. Middle.					
Maryland	d be ental ked o	To Be	George A		,						Cece1						
ary	shoul nd Ma mari	F	19a. Informant's N				19b. Mailir	ng Address			er or Rural R				te, Zip	Code)	
Ĕ	and 2 ealth a n 27 is		Donna E.	Kerler,	/Wife		1255	Haver	hill	Road	d Bal	timore	e MD	2122	9		
Je,	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		20a. Method of Dis				lace of Dispo	natory or ot	her place	9)	Date		20c. Loc	cation - Cit	or To	wn, State	
E	Page nent o			5 ☐ Other (Sp	3 □Removal from S ecify)	Wes	t Arun	del C	rema	tory	3-2-2	006	)dent	con, l	Mar	yland	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau	21. Singa ure of Funeral Service to the service to							ıs MD	MD 21227							
			23a. Part I. Enter shock, or he	the disease, of	omplications that ce	ed the deat										Approxima Interval Be	tween
	Physician		Immediate Cause disease or conditi	(Final		6	-iver		ure							Onset and	Death Pk
	/Medical Examiner		resulting in death)		Due to (	uence of);											
L	LAMINIC	<u>.</u>	Sequentially list c	equentially list conditions, any, leading to immodiate suse. Enter Underlying ause (Disease or injury						<del></del>							
厂	ted sit	nine	cause. Enter Und Cause (Disease o	lerlying or injury	200 10 (	77 25 a 001:00Q	an loc-cij.										
·	akecu al-tra	Examiner	that initiated event resulting in death)	is	cDue to (c	or as a conseq	uence of):								П		
8760,	cate be executed physician and the burial-transit	dlcal 8			d.										M		
9	ifficate g phy as the	edic			v												
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decede in the past 1: 1  Yes 2 9 Unknow	2 months? □ No		nth 2□Feta ant at time of d	I death 3	Ectopic pre Other (spe					2	3d. Date of Month		ry Day	Year
<u>α</u>	es that igned b be deta	by Pl	Part II. Other sign	ificant condition	ns contributing to de	ath but not res	ulting in the u	nderlying ca	use give	n in Part I		23e. Did to	obacco us	se contribu	te to th	e cause of	death?
rds	w require been sig should b	ed t		Hepay	titis C			_				1 🗆 Y	es 2	No 3[	] Prob	ably 4	]Unknown
Vital Records,		Completed		· · · · · · · · · · · · · · · · · · ·								24a. Was autop perfor		prior deat	to con h?	osy findings npletion of	available cause of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case refe examiner?	erred to medical							of Death (C						
of \	d is	မှ		No			ER/Outpatier			4 🗆 N	ırsing Home				Specify	)	
on C	Jing P	lon	27. Manner of Dea	5 Pending		f Injury n, Day Year)	28b. Time o	f 28	3c. Injury Work	:at :? ∕es 2.⊟		l. Describe h	iow injury	cocurred			
Division	or Attendi after death. Director: A in by the fu	icat	2 Accident 3 Suicide	investiga 6 🗆 Could no	ot be	of Injury - At ho	ome farm str			192 2		Location (S	Street and	f Number o	r Rura	Route Nur	n <i>ber</i>
Βį	after after Directory	Certification;	4  Homicide	determin		g, etc. (Specif		oot, lactory,	, 011100			City or Tow	m, State)				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	Certifying 2 Medicel E	Physicien: To the xeminer: On the ba	sis of examina	wledge, deatl tion and/or in	n occurred a vestigation,	at the tim in my op	e, date an pinion, dea	nd place, and oth occurred	due to the dat the time, d	cause(s) a date and	and manne place, and	r as st due to	ated. the cause(	(s)
	To th within To the	Me	29b. Signature an	d title of certifier				29c.	License	number			29d. Date	signed (N	fonth, i	Day, Year)	
				El		Medical 1	bother	R	ES-	- 00	0		Folin	iny 2	6	200	6
					no completed cause	of death (Item	23a) (Type,	Print)	. /		. 6 - 1		/	any o	-/		
	IO			411		Hepkins	Hospital	, 600	Non	the Wol	lfe Stree	t, Bal	timure	Mar	ylar	vel 2	1287
	Sta		31. Date filed (Mo.		A.	gistrar's Signa	ture					/	•				
	Registr	aı		MAR 0.2	2006	43	K A	acked									

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Mar	yland / l		irtment of Heatificate of De			giene Rag. Ño.	UUb	06257
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Agnes Lorraine	Kosiba					Feb.	2 /	$\frac{7}{7}$ , $2\overset{\text{Year}}{0}$	6 3:30 PM
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or Lo	cation of Death		4c.	County of Dea	ith
		- 10	Howard Co. Gen				Columb				Howar	d
	Funeral Director		5. Social Security Number 6. S 218 – 28 – 8227	ex 7. Age ( □M 2 🕱 F	In yrs. last bii	rthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birt Month, Pa 4/19	h y. 3°2")	C	thplace (State or Foreign ountry) ryland
	and w		Usual Residence of Decedent  10a, State 10b, County	1	Oc. City, Tow	n or Lo	cation					10d. Inside City Limits
	Aaryla f sho	ō	Md Baltin		,,		undalk					1 ☐ Yes 2 🛣 No
	the tage	Director	10e. Street and Number	ЮГС			10f. Zip Code			10g Citi	izen of What C	ountry?
	3a or	ΙD	7506 Lawrence	Road			2122	22			USA	,
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of Hisp	anic Origin? (Spe	cify Yes or No		14. Race - Am	
و	after or ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		1	Yes, specify Cuban,		Rican, etc.)		Black, Whi	te, etc.
2	hours after death with the Maryland tural, or items 23a or 28a-f show at Exertimer and be recilied at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Yes 2 K No	Specify:			Specify: W	hite
Ÿ	"natu	ete	15. Decedent's Ed (Specify only highest gra		16a	(Give	ent's Usual Occupation	on ing most of worki	ng	16b. Ki	ind of Business	/Industry
12	within 72 ene. than "na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			itress			Mir	nterli	ngs Rest.
0 0	filled Hygi ther int. I	S	17. Father's Name (First, Middle, Last)			71.02		3. Mother's Name	(First, Middle,			1165 11050.
Maryland 21215-0036		To Be	Leonard Karcze	wski					Cece		,	a
37	d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (		19b	. Mailin	g Address (Street and			_		
	nd 2 lith a 27 is r tra		Mrs. Carol Bak	er/Daught	er 11	9 (	Commodore	e Dr. B	altimo	re,	Md.	21221
e,	of Healt item 2		20a. Method of Disposition		20b. Place o	f Dispos	sition (Name of natory or other place)		ate		cation - City or	
altimore,	Pages nent of ant: if it ary or o		1  Burial 2  Cremation 3  C  1  Other (Specify			-	nislaus	3/4/	06	Bal	Ltimor	e, Md.
Balt	permit, Pages Depertment of I Important: If it any injury or o		21. Signature of Funeral Service Licen	S88			are of the state o					id. 21222
			23a. Part1. Enter the disease, or com	plications that caused th	e death. Do						, , ,	Approximate
U.	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1.0 7	100 /	*					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	of):	archan					minutes
	Examiner		One watch that we then	End-St			ral Dise	920				8/07
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c								, ,
H	acute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	· Lunge	anc	er						12/03
8760,	be executed sician and burial-transit	Ē	resulting in Geattry Last	Due to (or as a c	consequence	of):						70 -
87	ate	edicai		d. Diaver	25							20 years
×			IF FEMALE:	23c. If yes, outcome of	pregnancy						23d. Date of de	livon
Rox	law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2   4 ☐ Pregnant at tin	Fetal death		Ectopic pregnancy Other (specify)			-	Month Month	Day Year
Ö	w requires that the de been signed by the s should be detached	hysi	9 Unknown	9□ Unknown								
	ned be deta	by P	Part II. Dther significant conditions o	ontributing to death but	not resulting i	n the un	derlying cause given i	in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
ğ	quire on sig uld b								127	'es 2[	□No 3□P	robably 4 Unknown
ecords,	awre	Completed							24a. Was	an	24b. Were a	utopsy findings available
r	9 4 9	ШO								med?	death?	completion of cause of
VII	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				21	6. Place of Death				
o	S 0 0	10	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Ou	itpatient	3 DOA Other:	4 Nursing Hor	ne 5 Resid	enc <i>e</i> (	6 □Other (Spe	ocity)
	<b>5</b> 0 0 0 0	on:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Y		Time of	28c. Injury at Work?	2	8d. Describe h			
<u> </u>	tendi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be					2 No				
DIVISION	or Attending ifter death. Director: After in by the fune	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, fa (Specify)	arm, stre	et, factory, office	2	281. Location (S City or Tow	itreet and m. State,	d Number or Ri )	ural Route Number,
_	pitai ours a erai (		29a. Certifier 1 Cartifying Ph	valoian. To the best of	mu ka awla da			data and place a	and due to the			
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Att completely filled in by the fun	edicai	(Check only 2 Medical Exen	ysician: To the best of a liner: On the basis of ex and manner state	camination an	d/or inv	estigation, in my opini	ion, death occurre	ed at the time, o	ause(s) date and	place, and due	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	/ 0			29c. License no	umber	:	29d. Dat	e signed (Mont	h, Day, Year)
			1 Inna 1	Simo Vois	2		D351	70	4	2/25	3/06	
	15		30. Name and address of person who	A	7	(Type, F		143	2/- 2	11	,,00	
			31. Date filed (Month, Day, Year)	CONKLING 32. Segistrar's	Signature		BACTO	MD	7/20	7		
	Sta Registr		MAR 0 2 20		J. H.		ente					
Ε.			WALL OF CO	OO STATE	-	8	132					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:45 PM FEB 23 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K F 214-30-687 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 280 0 ane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 WNo If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 13190 "naturel", Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9DCB. 18 Mother's Name (First Middle Maiden Sumame) 185 nar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 280 Jaugn Ter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State to/ 4 ☐ Donation 5 ☐ Other (Specify) 22. If the and Address of Facility 21. Signature of Funeral Service Licensee Greene Kc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INJURY ANOXIC BRAIN Physician /Medical Due to (or as a consequence of) Examiner Sequentially list canditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, OBSTRUCTIVE LUNG. 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No RECURRENT PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed DIABETES HELLITUS 1 Yes RE No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural Division 5 ☐ Pending he Hospital or Attendi in 24 hours after death. he Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19924 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARIMA CHATURVEDI, 900 CATON AVENUE, BALTIMORE, MD

Registrar

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DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Paistrar's Signature

2006

			1 - For State Registrar	State of M	1arylan			nt of H		and M	_	giene Reg. No.		062	59
	Dhyciai	an.	1. Decedent's Name (First, Middle, Last,								2. Date of Dea	Day	/ Yea	r - /	of Death
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46	Examin	er	4a. Facility Name (If not institution, give		r)		4b. City		Location o			4c.	County of De		
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			Usual Residence of Decedent							'	БСР. 20	,, 1.	/ - /   1	lar y Lan	u
	how		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside	,
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	or 2	Director	10e. Street and Number				10f. Zi	Code				10g. Citi	zen of What	Country?	
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326	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. Item 27 is marked of thy time "naturel", or items 23a or 28a-f show other than "naturel", or items 23a or 28a-f show other traumatic event, it a Madical Examination must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? XNo		f Yes, spe 1 Tes	37	Specify:	, Puerto F	cify Yes or No Rican, etc.)		Black, W	hite, etc.	
ğ	2 hou	ted	15. Decedent's Edu	cation		16a. Dece	lent's Ust	al Occupa	ition			16b. Ki	nd of Busine	ss/Industry	
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<u>\frac{2}{5}</u>	2 should be and Mental is marked o	ို	Frank Allen Lips:  19a. Informant's Name/Relationship (T)			10h Madia	a Addrag	(Ctroot o	and Alcomba		elma St <i>I R</i> oute Numbe			Zin Code	
Maryland 21215-0036	d 2 sl th an th an traur		Frank A. Lipsitz				•					•			
ā,	Health Health tem 27 other tr		20a. Method of Disposition			lace of Dispo	sition /Na	me of			ltimore ate			or Town, State	
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			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caus ne cause on each	ed the death line.	n. Do not ent	er the mo	de of dying	g, such as	cardiac o	r respiratory ar	rrest,		Approxim Interval B	letween
1 3	Physician		Immediate Cause (Final disease or condition	HYPE	RTRO	PHIC	ct	nnic	MYO	PAT	MY			Onset an	d Death
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Вох	death certific e attending p id for use as	Physician/Med	230. Was decedent pregnant	3c. If yes, outcom			Bectopic p	regnancy					23d. Date of		Voes
	at the dea by the at stached fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant 9☐ Unknown		eath 5	Other (s	pecify)					Month	Day	Year
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000	endir seth. or: Af he fu	atic	2 Accident investigation			,-,	М		Yes 2 □ !	No					
Division of	i or Attendater deetl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building.	Injury - At ho etc. <i>(Specif</i> )	ome, farm, sti y)	eet, facto	y, office		2	28f. Location (S City or Tov			Rural Route N	imber,
)	d hours funeral	edical C	29a. Certifier Certifying Phy (Check only one)	sician: To the be ner: On the basis and manner	of examina	wledge, deat tion and/or in	n occurred vestigatio	at the time n, in my op	ne, date and pinion, deal	d place, a	and due to the ed at the time,	cause(s) date and	and manner i place, and c	as stated. lue to the cause	9(s)
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)			+ Frederes	Kle	m	0		130	330	0		Feh	PUATY	24,2	006
	$ \mathcal{T} $		30. Name and address of person who co	ompleted cause o	f death (Item	n 23a) (Type,	Print)	<u> </u>		,	<u></u>	1		-)	
	U		Frenerica Ki	HNON	10 3	449	Cu:	Iken	s Az	$e^{H}$	300 1	5-17	move	24, Z MO 2	1229
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			1 - For State Registrar	State of	Marylan				ealth a		lental Hy	giene		06	260
H	Physici /Medic	_	Decedent's Name (First, Middle, L     Mary Lowe	ast)							2. Date of De Month Febru	Day	γ <sub>θα</sub> 23, 200	r	me of Death 0:20P M
	Examin		4a. Facility Name (If not institution, g		ber)		4b. City	, Town, or	Location of	of Death		4c.	County of De		
ш			Friends Nursing 5. Social Security Number 6.		. Age (In yrs.	la st highday)		ndy S	prine		8. Date of Bi		ontgome		
	Funeral Director		124-14-1791	1□M 2\\ F	. Age (m y/s. 92		Months		Hours	Min.	July 1	av. Year)		Country) taly	tate or Foreign
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	th the	Director	10e. Street and Number	шету	ROC	VATITE		p Code				10g. Cit	izen of What	Country?	
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4			30. Name and address of person wh					L 1 1 1 -	D	***	01	M=	.1 1	20022	
	Sta		Christopher J.  31. Date filed (Month, Day, Year)  MAR 0 2 7	32 84	gistrar's Signa	ature			υr1	ve,	Olney,	mary	ıand	ZU032	
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		•	For State Registrar	State of M	Marylan	d / Depa	artment <i>rtificate</i>	of H	eaith a Death	and M		glene Reg. No.	06	06261
23	Physici	an	1. Decedent's Name (First, Middle, Last	)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Mary Lorden				1				Februa		, 2006	7:25 A M
	Examin	er	4a. Facility Name (If not institution, give Genesis Heritage	street and number	9r)		4b. City, T		Location o	of Death			ounty of Death	
₹*.	Superal.	\$ \$0 =====	5. Social Security Number 6. Se	x 7.	Age (In yrs.	last birthday)	If Under 1	Year	If Under a		8. Date of Birt	h	timore	place (State or Foreign intry)
	Funeral Director			⊒м 2КХ/г	75	Yrs.	Months	Days	Hours	Min.	(Month, Da)			yland
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo								10d. Inside City Limits
	Aaryla F show	ō		_	100.01	y, rown or Ec	ocation							1 ☐ Yes Style
	the h	rect	MD Baltimore	<u>e</u>			10f. Zip (	Code				10g. Citize	n of What Cou	
	3a or	0	8053 Wynbrook Roa	ad			212	24				U.S.	Α.	
	death	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No-		. Race - Amer Black, White	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23s or 28e-f show or other traumatic event, the Madical Examinar must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	₩No	į.	1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,		S		White
00	hour ture!	ed b	3 ☐ Widowed 4 X Divorced  15. Decedent's Edit	Year or Date	s: 	16a, Dece	dent's Usual	Occupa	ation			16h. Kind	of Business/l	
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Mai	d 2 st th and th sh traun		19a. Informant's Name/Relationship (T) David Lorden/Son	ypa, Print)							i Route Numbe	505=V		
ē,	Health tem 27 other tr		20a. Method of Disposition		20b. F	Place of Disponentery, cre	sition (Nam	e of	Koac	1, 152	altimor		tion - City or 1	
9	Pages nent of I int: If it		1 ☐ Burial 2X Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		le	tro Cr			1	12-27	7-06	Ralti	more. N	M)
Baltimore,	permit. Pages Department of Important: If I eny Injury or	- 1	21. Signature of Euneral Service Licens		->				s of Facility	yChar	les S.	Zeil	er & So	on, Inc.
<u>m</u>	89 = 9		1 day	13//			6224	Eas	tern	Ave.	, Balt:	imore		21224
8760,	Physician /Medical Examiner physician und physician und physician und physician und physician ph	Ical Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List period the shock of heart failure. List period disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c. Due to (or	CRE as a conseq as a conseq	uence of):		M						Interval Between Onset and Death
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of Vital Records,	The age	Complet									24a. Was autop perfo 1 Yes		24b. Were aut prior to c death? 1  Yes	opsy findings available ompletion of cause of
/ita	ystcian: T is certifical director, p	Be (	25. Was case referred to medical examiner?						26. Place	of Death	Check only o	ne)		
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Divi	or Al	Certifi	4 Homicide determined	286. Place of	Injury - At he etc. (Specif	ome, farm, st	reet, factory,	office		distribution of the state of th	28f. Location (5 City or Tov		Number or Ru	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	rsician: To the be iner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred a vestigation,	it the tim in my op	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	[	5 39000	1000V/ <u>945</u> 4			number				signed (Month	
)	<b>h</b>		Laurede	16 11	ME	MD		り	21	150		2/2	24/0	-6
	Sta Registr		30 Name and address of person who of the state of the sta	School Sc	of death (Item	n 23a) (Type,	Print)  YRE	1-	Pla	Co	Dun	-fall	KMI	6 21222

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Ruth Ann Long FEBRUARY 27,2006 5:57 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 □ F 2/07/1955 51 Maryland 220-66-5113 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental hygiene.
em 27 is marked other than "natural", or items 23s or 28s-f show ther traumatic event, the Medical Examinar must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 400 C Secret Bend 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Unemployed 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) æ Doris Deremer Robert Long ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health as importent: if item 27 is any injury or other traugonce. 400 C Secret Bend Glen Burnie, MD 21061 Mrs.Katrina Jenkins / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Hilltop Service Corp. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/02/2006 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LicenseeKimberly Davidson 22. Name and Address of Facility 5305 Harford Rd. Baltimore Maryland 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner EARLY BOWEL ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) signed by the e Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ○ Yes 2 □ No 24a. Was an this certificate has al director, page 2 autonsy 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours effer death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To ate of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗆 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2-28-06 D 28244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE TOUSON MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Registrar

n 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 21 per fh 9853 3-2-06 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** :15 A Feb. 28 2006 Louis J. Matthew /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3924 Fait Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1₩ 2□ F 86 Yrs. 216-09-7450 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or iteme 23a or 28a-f ahow tre Medicel Examiner must be nutified at 1 XYes 2 No MD Baltimore Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 3924 Fait Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

★□ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. College (1-4or 5+) E.Eyring&Sons Elementary/Secondary (0-12) Carpenter 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fi f Health and Mental H item 27 is marked otl John L. Matthew Catherine Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2: iment of Health a tant: if item 27 is Deanna Matthew /wife 3924 Fait Ave. Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 5 BaltimoreNAtional 3/1/06 permit. Page Department of Importent: if any injury or once. 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee R. Terry Connelly per dvr 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LY MPHOMA **Physician** NON-HODGKIN ONE MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (o. as a consequence of) Examine attending physicien and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ DISGASE 1 Yes 2 No 3 Probably 4 Unknown ARTGRY COROMARY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has b autopsy 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ē This After the 27. Manner of Seath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after c To the Funerel Direct completely filled in by 4 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HEMATOLDG IS ? 03/01/2006 D-51555 MD, ONCOLOGIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, SUITE#2300, BALTIMORE MD 2/237 , 9103 FRANKUN SOURCE SGIN AUNG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 2 2006

DHMH 17 Rev 1/2001

ORIGINA

Lisa McNeil 06-01349 crn

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			1 = For State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		rtificati					Reg. No	IJIJ	b	0626	G (
			1. Decedent's Name (First, Middle,	Last)					·		2. Date of De	ath			3. Time of	Death
	Physici /Medi		Lisa	McNeil							Februar	y 2.	ž, 2	2006	10:17	Ам
	Examir		4a. Facility Name (If not institution,				,		Location o	of Death		4c.	. Count	ty of Death		
L			Johns Hopkins Ba					ltim						N/A		
	Funeral Director		5. Social Security Number 564-25-0611	6. Sex 7 1 ☐ M 2 🔏 F	. Age (In yrs.	iast birthday) 2 Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	h y, Year)		9. Birth	place (State or intry)	<sup>r</sup> Foreign
			Usual Residence of Decedent			144					MAY 29	, 19	63	Cal:	ifornia	
	nylanc how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					-			10d. Inside Cit	y Limits
	Ba-f-	cto	Maryland Anne A	Arundel		Laur	el								1 ☐ Yes	2 <b>X</b> No
	within 72 hours after deeth with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow he Medical Exeminar must be notified at	Directo	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of	f What Cou	intry?	
	e 23a		13 N. Carol Str						724					USA		
_	ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Force d 1 Tyes 2	es?	.S.   13.	Was Deced If Yes, spec	lent of History of Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)			ace Ameri ack, White,	ican Indian, , etc.	
5	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	2[XNo	Specify:			İ	Speci	ity: W	hite	
9500-6121	natura	Completed	15. Decedent's			16a. Dece	dent's Usua	I Occupa	tion			16b. Ki	ind of F	Business/Ir	ndustry	
7	thin /	pje	(Specify only highest Elementary/Secondary (0-12)	College (1-4	tor 5+)	life.	kind of wor DO NOT us	n aone a se retir <del>e</del> d)	uring most	of worki	ng					
7	led w lygier her th			5+			Paral							ting	Firm	
and	ntal H	Be	17. Father's Name (First, Middle, La								(First, Middle,			,		
<u>ڇ</u>	hould d Mei mark matic	2	James H. Mo			105 14-15-		(24		oro				yre		
<u> </u>	id 2 s Ith an 17 te u		Jeffrey L. Green		CO							lumber, City or Town, State, Zip Code) ., MD 20724				
ā,	s 1 ar f Hea item		20a. Method of Disposition	юран/тан	20h F	lace of Disno	cition /Nam	ne of	Ţ		ate	20c. Location - City or Town, State				
Ē	Page ento nt:#		1 ☐ Bunal 2 XCremation 3 4 ☐ Donation 5 ☐ Other (Spe			emetery, crem				3/2/	06	Balı	t i m/	ore,	MD	
Баппо	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Deperment of Health and Mental Hygiene. Immortant: If them 27 is marked other than "natural; or iteme 23a or 28a-1 ehow eny injury or other traumatic event, the Modical Examination and the notified at ODGE.	4 Donation 5 Other (Specify)  Metro Crematory, Inc. 3/2/06  21. Signature of Facility  MacNabb														
מ	827 28		Edward A	regorchik			301 F	rede:	rick	Road	Catons	vil.	le,	MD 2	1228	
			23a. Part1. Enter the disease or co shock, or heart failure. List or	omplications that cau nly one cause on eac	used the deatl sh line.	n. Do not ent	er the mode	of dying	, such as o	cardiac o	r respiratory ar	rest,			Approximate Interval Betw	een
1	nysician	ě V	Immediate Cause (Final disease or condition	a Hyperte	nsive ca	rdiovas	cular d	liseas	e com	licat	ed by pu	Imone	ar w 1	mente	Onset and De	aath
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):										
		Ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequ	uence of):	_							_		
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<b>j</b>	the de	ysic	1 Yes 2 No 9 Unknown	4⊟ Pregnan 9⊟ Unknow	nt at time of de n	eath 5	Other (spe	ecify)								-
Ļ	that ed by deta		Part II. Other significant conditions	s contributing to deal	th but not resu	ulting in the un	nderlying ca	use giver	n in Part I.		23e. Did to	bacco u	se con	ntribute to the	he cause of de	ath?
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	The ste he	Completed									autops perfor			prior to co death? 1 Dres	mpletion of cau	use of
<u> </u>	entifica	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or			7.55	2010	
5	hysic this c	2	1 ZYes 2 □ No	Hospital: 1 Inp		ER/Outpatien			4 LI Nur	sing Hom	ne 5 🗆 Reside	ence 6	3 Oth	her (Specif	y)	
	After funer	- Lo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	28b. Time of Injury	M 28	C. Injury			8d. Describe hi	ow injury	y occur	rred		
?	deat deat ctor: y the	ertification:	2 Accident investigat 3 Suicide 6 Could not determine	t be 290 Blace of	Injury - At ho	me farm stre			es 2□N		8f. Location (S	treet and	d Numi	her or Burs	A Poute Number	0,
<b>.</b>	a after	Certi	4 Homicide	building,	, etc. (Specify	)	, Lectory,	omoo			City or Town	n, State)	)	our or more	I HOUSE WASSIDE	31,
	ospit hours unere ly fille		29a. Certifier 1 Certifying	Physician: To the be	est of my know	wledge, death	occurred a	t the time	, date and	place, a	nd due to the c	ause(s)	and m	anner as si	tated.	
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within carter death.  To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	fedical		aminer: On the basi and manner	s or examinat	ion and/or inv				occurre	d at the time, d	ate and	place,	and due to	the cause(s)	
1	o tive co	Σ	29b. Signature and title of certifier	11 (1-				License					-	ed (Month,		
	" and		produce 1	1. 1078	mus		ļ	0.C.	M.E.		E	ebr	uar	y 24,	2006	
1	Both		30. Name and address of person wh		of death (Item			<b>.</b>	L 5	7, .		_	4	01.00	1	
	Sta	te	31. Date filed (Month, Day, Year)	1	istrar's Signat	ure		ree	г, ва	TCIM	ore, Ma	ryl	and	2120	1	
	Registra		BEAD A G 1	inne A	A		3 P									

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  Lois J Maxwell  4a. Facility Name (If not institution, give street and number)  7658 Bush Avenue  Pasadem  Funeral Director  235-40-4363  1. Decedent's Name (First, Middle, Last)  Maxwell  4b. City, Town, or Location  Pasadem  7. Age (In yrs. last birthday)  Months Days Hours	la ler 24 Hrs. 8. Date of B. s Min. (Month, D	ry 28, 20	
Lois   J   Maxwell	Februa on of Death  aa ler 24 Hrs. s Min.  8. Date of 8 (Month, D	ry 28, 20 4c. County of	06 11:05A <sup>™</sup>
Examiner 4a. Facility Name (If not institution, give street and number)  7658 Bush Avenue  Pasadem  Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I	la ler 24 Hrs. 8. Date of B. s Min. (Month, D	·	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Und	ler 24 Hrs. 8. Date of B	A	Death
Funeral 1 M X F TO Months Days Hours	s Min. (Month, D	Anne A	rude1
Director 235-40-4363 78 Yrs.	0ct.1	lay, Year)	Birthplace (State or Foreign Country)
		1,1927	WV
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d, Inside City Limits
Anne Arundel GLen Burnie			1 ☐ Yes 2 ☐ No
9 87 2 10. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
MD. Anne Arundel GLen Burnie    MD.   Anne Arundel   GLen Burnie     106. Zip Code			at Country ?
410 7th Avenue 21060	Origin? (Specify Ves or N	USA	American Indian,
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic I Tyes 2 12 No	can, Puerto Rican, etc.)	Black,	White, etc.
1 Yes 2 No Speci	ify:	Specify:	White
To a state of the		16b. Kind of Busi	ness/Industry
(Specify only highest grade completed)  (Give kind of work done during m  [ife, DO NOT use retired]  Elementary/Secondary (0-12)  College (1-4or 5+)	nost of working		,
15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during more properties of the complete of the complet		Own Hor	ne
Elementary/Secondary (0-12)  To be the first of the first	ther's Name (First, Middle	e, Maiden Sumame)	
Austin Baghaw  Austin Baghaw	Ann Shrout		
등 등 본토 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num	nber or Rural Route Numi	ber, City or Town, St	ate, Zîp Code)
Mr. Randall Cogar / Son 814 Wampler Road  20a. Method of Disposition 20b. Place of Disposition (Name of competery crematory or other place)	Middle River	r. MO. 213	220
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - C	
T文 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Maryland Vets.Cem.	March 3, 2006	Crownsvi	I1a MD
21. Signature > Funeral Sevier) Licensage 22. Name and Address of Fac			Home, P.A.
a a a a a a a a a a a a a a a a a a a	ue SW Glen E	Burnie MD	21061
Physician (Medical Examiner  28. PArt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Cause (Disease or injury)	as cardiac or respiratory	arrest,	Approximate Interval Between Interval Between Onset and Death
C. Due to (or as a consequence of):    Open continuous of the cont		23d. Date Month	,
😑 👗 🖰 1. Part II. Other significant congridings contributing to death but not resulting in the underlying cause given in Par	rt I. 23e. Did	tobacco use contrib	ute to the cause of death?
	10	Yes 2□No 3	Probably 4 Unknown
The law requirements to the law spen single and spen single an	24a. Wa	s an 24h We	ere autopsy findings available
The law the law sage 2 comp	auto	opsy prid	or to completion of cause of ath?
			Yes 2ENS
So the state of long to the st	ace of Death (Check only		
0 5 5 7	Nursing Home 5 Pes	sidence 6 Other how injury occurred	
C 5 9 0 1 Natural 5 Pending (Month, Day Year) Injury Work?			
To the project of the		(Street and Number	or Rural Route Number,
27. Mann of Death   1   Natural   2   Accident   3   Suicide   4   Homicide   4	City or To	own, State)	
Company   Comp	and place, and due to the death occurred at the time	e cause(s) and mann e, date and place, an	ner as stated. d due to the cause(s)
29b. Signature and title of certifier 29c. License number	ər	29d. Date signed (	Month, Day, Year)
12009	4	03/0	1/06
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-1	100/0	1
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ellist Gorbaly My 141 Medium Park Di	rive, Glea	Ourhit,	md, 2106
State Registrar 31. Date filed (Month, Pay, Year) B2 (legistrar's Signature VIAR 0.2, 2006			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 State
Registrar Amend Item #22 Per FH C852 3/02/16/64tapof Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Year John Milton Maynon 9:22 AM 24th 2006 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Medical Center (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1**X**M 2□ F 219-14-007C Usual Residence of Decedent Director 10a. State 10b. County Town or Location 10d. Inside City Limits or than "natural", or iteme 23a or 28a-f ehow The Medical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: if item 27 ie marked other than "ne eny injury or other traumatic even" Elementary (0-12) College (1-4or 5+) 17. Falher's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition

1 D Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 11 CQ leur LOP IC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final As Diration **Physician** pneumonia Drougs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1.5 years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No

Division of Vital Records, P.O. Box 68760,

this certificate has been signed by the ettending physicien and ral director, page 2 should be detached for use es the burial-transit To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifica ieral Director: After this certific filled in by the funeral director,

Be 25. Was case referred to medical examiner? Certification: To 1 ☐ Yes 2 🕱 No

29a. Certifier

(Check only one)

27. Manner of Death 1 Naturai 5 Pending 2 Accident 3 ☐ Suicide 4 Homicide

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

Hospital: 1 X Inpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 🔯 No

🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 X No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

	1		_				
30. Name and	address	s of person	who comp	leted cause of	death (Item	23a) (Type	, Pri

2 2006

Rogers

Jongthan S. 31. Date filed (Month, Day, Year)

MARO

29b. Signature and title of certifier

32 Registrar's Signature

Greene Street Baltimore, 10

completely

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1,perMD,g853, 3/15/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Tommie Lewis Mizell Month 2 200්රී Physician 26 Mizel 8:36p. **Tommie** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA 4916 Lanier Avenue Apt. A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 ☐ F Yrs. Director 20 NC 48 245-72-1066 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location item 27 is marked other then "neturel", or iteme 23s or 28s-f shov other traumatic event, the Madical Examinar must be notified at X□Yes 2□No Director Baltimore NA MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 4916 Lanier Ave. Apt A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or ite 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify ۵ 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Conductor Railroad na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Joyner Grady Mizell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is eny injury or other trausons. 4916 Lanier Ave Apt A, Baltimore, Md 21215
ace of Disposition (Name of Date 20c. Location - City or Town, State Judy Mizell-Wife
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baptist Ch. 3/4/06 Northeastern, Severn 21215 22. Name and Address of Facility Baltimore, Md. 21. Signature of Funeral Bervice Licensee 4300 Wabash Ave. March F.H. West 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal **Physician** tallure reser disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 20 months Chalangio Carcinana Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) n signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Junknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b rector, page 2 si 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours at 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28,2006 hyle D 23809 February MU dustin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Creere St., Baltimore, MD 21201 Ruston Dayle mis, Caucer Ctr., 32. degistrar's Signature 31. Date filed (Month AR 0°2 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 27, 2006 **Physician** Mancy Catherine Macek 4:00 AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A2011 Bank Street Baltimore If Under 1 Year If Under 24 Hrs. Min. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. July 30, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Yrs 1938 North Carolina Director 212-36-7501 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be nutified at 1 √Yes 2 No Director N/A Maryland Raltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2011 Bank Street 21231 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2€No Specify White þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 te marked other then ' College (1-4or 5+) Elementary/Secondary (0-12) University 12 Payroll Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Jordan Rush Helen Elizabeth Ring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 Bank Street Baltimore, Maryland 21231 Diane Pargament / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State permit. Page Department of important: If any injury or once. 03/02/2006 Timonium, Maryland Dulaney Valley 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licensee athleen Weber 401 S. Chester Street Baltimore, Maryland 21231 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Respiratory Immediate Cause (Final **Physician** arrest minutes disease or condition resulting in death) /Medical Due to (dr as a consequence of): Examiner Lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to ( a a consequence of): physician and s the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the infector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown arynx, squamous 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 2 XNo : After this certifical funeral director, r or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 44717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carol New II MD 7801 York Rd, Suite 224, Towson, Maryland 21204 10 32. Registrar's Signature 31. Date liled (Month, Day, Year) State 111R 0 2 2006 Registrar

	1 - State of Pagistrar	Maryland / Department of Health and N Certificate of Death	Reg. No. 06 06270
	Decedent's Name (First, Middle, Last)		Date of Death     3. Time of Death
Physician /Medical	Arthur Spe	encer Moore Sr.	February 25 2006 1140 AM
Examiner	4a. Fecility Name (If not institution, give street and number	4b. City, Town, or Location of Death	4c. County of Death
	ST Agnes HOSPI	Age (In vis last hirthday) If Under 1 Year I If Under 24 Hrs.	
Funeral Director	215-22-8877 XDM 2DF	Age (In yrs. last birthday)    If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.     Min.   Min.   Min.   Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 04 12 24 MD
pug *	Usuel Residence of Decedent  10a, State 10b, County	10c. City, Town or Location	10d. Inside City Limits
n the Maryland r 28a-f show poulfied at	MD NA	Baltimore	1 <b>X</b> Yes 2 ☐ No
the h	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
State death with the Mar riteme 23s or 28s-f si rither mans be notified Funeral Director	712 Whitmore Ave	21216	U.S.A.
ter death	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	
030 urs a	1 Never Married Married 1 Ty Yes 2 If Yes, Give Year or Date	□ No 1 □ Yes 🍇 No Specify:	Specify: Black
	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business/Industry
Ind 21215-0 tal Hygiene. tal Hygiene. d other than "natu event, the Andical Be Completed	9th grade College (1-4c) na	Brick Layer	Beth Steel Corp.
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 le marked other than eny injury or other treumstic event, tre. Magnes. To Be Comp	17. Father's Name (First, Middle, Last)  Anthur S. Moore		ia Blackston
shou and M	19a. Informant's Name/Helationship (Type, Print)	19b. Mailing Address (Street and Number or Run	ral Route Number, City or Town, State, Zip Code)
and 2 ealth a	Lillian B. Moore-Wife	712 Whitmore Ave, F	Baltimore, Md 21216
or He	20a. Method of Disposition  N□ Burial 2 □ Cremation 3 □ Removal from Sta	comptent, cromaton, or other place)	Date 20c. Location - City or Town, State
Fages ment of lant: If its ury or o	4 Donation 5 □ Other (Specify)	Garrison Forest Vet. 3	3/6/06 Owings Mills, Md
Baltimore, permit Pages 1 ar Department of them important: if item eny injury or other	21. Signature of Funeral Service Licensee  - Urme A. hump	22. Name and Address of Facility  March F/H West 4300 Wabash Ave	Baltimore, Md 21215
	shock, or heart failure. List only one cause on each	sed the death. Do not enter the mode of dying, such as cardiac n line.	or respiratory arrest, Approximate Interval Between Onset/and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)  a  Due to (or	as a consequence of):	Hours
Examiner ចំ	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):	
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or Due to (or Due to (or Cause))		
a price	Due to (or	as a consequence of):	
687 tifficate ng phys as the			
Box Bath cer attendir tor use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 Fetal death 3 Ectopic pregnancy t at time of death 5 Other (specify)	23d. Date of delivery  Month Day Year
ds, P.O. ds, P.O. uires that the d signed by the id be detached d by Physic	An a ha		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
of Vital Records, Physician: The law requires I This certificate has been signe rial director, page 2 should be. TO Be Completed by	Coronary art		24a. Was an autopsy findings available prior to completion of cause of
Vital Rocardinate The certificate his rector, page	Chronic renal	fuilure	performed? death?  1 Yes 2 No 1 Yes 2 No
Vital F Vital F certificate rector, page	25. Was case referred to medical examiner?	Othor	th (Check only one)
n of Vital ing Physician: After this certifical inertal director, pon: To Be O	T Tes 2 7NO	atient 22 EN Outpatient 3 DOA 4 Nursing Ho	ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
on on diding Fig.	1 Natural 5 Pending (Month, 2 Accident investigation	njury 28b. Time of 28c. Injury at Work?  M 1 Yes 2 No	
Division c rs after death rs after death el Director Mier t ed in by the tunera Certification:	3 Suicide 6 Could not be determined 28e. Place of building,	Injury - At home, farm, street, factory, office etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospi 4 hou Funer iely till		est of my knowledge, death occurred at the time, date and place, s of examination and/or investigation, in my opinion, death occur	
within 2 To the within 2 To the complet	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
F 3 F 9	> /Quall / H	734543	February 25, 2006
1×1	30. Name and address of person who completed cause of ROVIN H. SCHINGS (M)	of death (Item 23a) (Type, Print)  900 Catin Avenue	Bultimore, Maryland 2,1229
State Registrar	31. Date filed (Month, Pay, Year) 32 Reg	Istrar's Signature	

			1 - For State of Ma: Registrar	ryland / Depa <i>Cei</i>	artment of H			iene	06271
			Decedent's Name (First, Middle, Last)				2. Date of Dear Month	Day Y	3. Time of Death
	Physici: /Medic		Mildred Meeres				Feb 27	, 2006	6:45 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Deat	h	4c. County of	
			Continuum Care  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Syesvil If Under 1 Year	Le If Under 24 Hrs	8. Date of Birth		11. County  Birthplace (State or Foreign
Г	Funeral Director			5 Yrs.	Months Days	Hours Min.		, Year)	New York
	ס		Usual Residence of Decedent				0 0110 21	, 1710	
	arylan	<u>.</u>		10c. City, Town or Lo					10d. Inside City Limits
	Ba-1:	ecto	Maryland Carroll	Sykes				0- 00	1 ☐ Yes 2/TXNo
	with t	Dir	10e. Street and Number 7568 Main Street Apt 3		10f. Zip Code	1784	'	Og. Citizen of Wh	
	death	era	11. Marital Status 12. Was Decedent E	ver in U.S. 13. \	Was Decedent of H		specify Yes or No-	14. Race	- American Indian,
9	after or iter	by Funeral Director	Armed Forces?  1 Never Married 2 Married 1 Yes 25 No If Yes, Give 1		f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Puer Specify:	to Rican, etc.)		White, etc.
203	Jurai',	d by	3 Widowed ALX Divorced Year or Dates:		ΛΛ			Specify:	White
15	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Medical Exam for multiple at the Medical Exam for multiple at	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busi	ness/Industry
21215-0036	withi iene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+ 12	)	ecretary			Federa	1 Government
	e filec al Hyg othe vsnt,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,		
Maryland	Menta	To	William Reedy				lle Garha		
Nar	2 sho	1	19a. Informant's Name/Relationship (Type, Print) Isabel M. Cek (Daughter)		•		ural Route Numbel 3, Sykesi		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-1 show any Injury or other traumatic event, Ite Medical Expri is a must be recitified at once.		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	1	-		ity or Town, State
altimore,	ages int of t: if it		1 Burial ACCremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, crer	natory or other plac	1			
Itin	nit. P artme ortan Injur.	- 1	21. Signature of Funeral Service/Licensee	Lee Crei	IIACOTY II 2. Name and Addre	Sarch I.	2000	Clinton T	Maryland nc 6633 01d
ä	Departiment Department of the suny in the suny in the suny in the suny in the suny in the sunce of the sun the sunce of the sun the su		Hous & Frank moors				Road, Cl:		
	77		23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Pnysician	1	Immediate Cause (Final disease or condition	nenha					Onset and Death
	/Medical Examiner		Due to (or as a	consequence of);					
		er	Sequentially list conditions, if any, leading to immediate b. Due to for as a	consequence of):					
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events	ema					
Ó	e exection and arrial-tr		The state of the s	consequence of):	** * * * *				
8760,	icate be executed physician and s the burial-transit	dical	d. Hack	onunal	mass	_		_	
9 X	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of	f pregnancy				23d. Date	of delivery
Вох	death atten	cian	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)	<u> </u>		Mont	
Ö.	t the by th ache	hys	1 Yes 25 No 9 Unknown 9 Unknown						
s, P		ру Р	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.		_	oute to the cause of death?
ord	law requires as been sign 2 should be	eted					1 🗆 Y		
Vital Records,	0 = 0	Completed					24a. Was a autops perfor	sy pri	ere autopsy findings available or to completion of cause of ath?
a	ilclen: The certificate har rector, page	e Co	25. Was case referred to medical			26 Place of Do	1 ☐ Yes ath (Check only or	-30-12-	Yes 2 No
>	Physicien: this certific ral director.	o B	examiner? 1 ☐ Yes XX No Hospital: 1 ☐ Inpatien	t 2 ER/Outpatier	nt 3 DOA Oth	05	Home 5 Resid		(Specify)
u of		n: T	27. Manner o Death 1 ☐Natural 5 ☐ Pending 28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	f 28c. Injur Wor		28d. Describe h	ow injury occurred	d
Siol	Attending or death.	catlo	2 Accident investigation			Yes 2 □ No	f		
Division	for Attendate death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injure building, etc.	ry - At home, farm, str (Specify)	reet, factory, office		City or Tow		or Rural Route Number,
ч	e Hospital 24 hours a Funerel I etely filled	al Ce	29a. Certifier 1 Certifying Physicien: To the best of	my knowledge, deat	h occurred at the tir	ne, date and plac	e, and due to the c	ause(s) and man	ner as stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edica	(Check only one) 2 Medicel Examiner: On the basis of and manner state	examination and/or in					
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	4 MN	29c. Licens	e number	210 3	9d. Date signed	(Month, Day, Year)
•	_		30. Name and address of payens who completed cause of the	ath (Item 23a) (Time	Print)		-/0	16-2	(Month, Day, Year) 8-06 11) 21159
	10			ath (Item 23a) (Type,	9 male	olm du	ive, built	minsty t	m 51122
	Sta		31. Date filed (Month, Day, Year)  MAR 0 2 2006	r's Signature	de)				
	Registi	aľ	MAR 0 2 2006	200	Selection .				

		1 - For State Registrar	State of Marylan		artment of H tificate of			ene 1. No. 006	06272
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     Aa. Facility Name (If not instifution, give s	treet and number)	^	4b. City, Town, o	r Location of Death	2. Date of Death Month Fe b	Day Year 25 300 4c. County of Dea	
Funeral Director		5. Social Security Number Sex 188-34-6598	Behabilitation 7. Age (In yrs. 6:		Bout- If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	CITY (ear) 9.8ii PEN	rthplace (State or Foreign ountry) INSYLVANIA
ne Maryland 8a-1 ehow	Director	10a. State 10b. County MD CITY		y, Town or Lo	ORE				10d. fnside City Limits 1 X Yes 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I mimportent: If time X7 Is marked other than "natural", or items 23e or 28e-1 show any injury or other treumatic event, the Madical Exaction of the matter national angles.	Funeral Dire		2. Was Decedent Ever in U Armed Forces?	.S. 13. \	10f. Zip Code  212  Was Decedent of H f Yes, specify Cub	24 dispanic Origin? (Sp an, Mexican, Puerto		J. Citizen of What C USA 14. Race - Am Black, Whi	erican Indian,
in 72 hours aft	Completed by F	1 Never Married 2 Married 3 Widowed 4 Minorced  15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced	1 ☐ Yes 2X No  dent's Usual Occup kind of work done DO NOT use retire	ation during most of work	king 16	Specify: W	HITE s/Industry
inal y fall a L L J-0000 of 2 should be filed within 72 hours aff this and Mental Hygiona 27 Is marked other than "natural", or r treumatic event, the Manical Exact	Be	Elementary/Secondary (0-12)  1 2  17. Father's Name (First, Middle, Last)  C.L.	College (1-4or 5+)  ARENCE	PHLEG			ne (First, Middle, Ma HERINE	FINANCE aiden Sumame) TROX	-
T and 2 shout Health and Me and 27 is mark that treumatic	To	19a. Informant's Name/Relationship (7); MICHAEL MUSCALL: 20a. Method of Disposition	ре, Print) I – SON	3315	•	and Number or Ru	ral Route Number, ( EAST, FII	City or Town, State,	Zip Code) MD 21048
Dallinore, permit. Pages 1 ar Department of Hea Importent: If itam any injury or otha		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Sign that of Fur ral Service License	emoval from State ALL	COUNT	natory`or other pla Y CREMA Name and Addre	TION 3/	1/06 SY	YKESVILL FUNERAL	E, MD HOME
Physician		23a. Part1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.	h. Do not ent	er the mode of dyli	ng, such as cardiac	WESTMI or respiratory arres	ıt,	MD 21157  Approximate finterval Between Onset and Death
	dicai Examiner	resulting in death)  Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq  Due to (or as a conseq	uence of):				-	
that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnanc Other (specify)	,		23d. Date of de Month	olivery Day Year
	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause gr	ren in Part I.	1 🗆 Yes	2 □ No 3 □ P	to the cause of death? Trobably 4 12 Onknown
The tar ate has page 2	e Completed	25. Was case referred to medical				26. Place of Dea	24a. Was an autopsy performs 1 Yes 2 th (Check only one)	prior to death?	utopsy findings available completion of cause of
Attanding Physician: r death. setor: After this certific by the funeral director,	ation; To B	examiner?  1 Yes 2 No  17 May er of Death Natural 5 Pending Accident investigation	ospital: 1  Inpatient 2  I  28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	er: Nursing H y at k? Yes 2 □ No	ome 5 Residen		acify)
pitel or ours afte erel Dir	al Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	(y)		ne, date and place	City or Town,		
To tha Hospitel within 24 hours a To tha Funerel I completely filled	Medical		ler: On the basis of examina and manner stated.		vestigation, in my o	epinion, death occur e number	rred at the time, date	e and place, and du	e to the cause(s)
Sta Registr		30. Name and address of person who co	pleted cause of death (Item	X NO	Print)	Alace	· Dura	talk i	nD 21222

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 28, 2006 **Physician JEROME** MARKOWITZ 1:20 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 3023 GLEN AVENUE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/15/1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 219-32-8735 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits oriant: if itsm 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examinar must be notified at √ Yes 2 No Funeral Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3023 GLEN AVENUE 21215 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☑ Never Married 2 ☐ Marned Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ RABBI RELIGION permit Pages 1 and 2 should be file.
Department of Health and Mental Hygher any injury or other 1-2 page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SOLOMON CHANA HIRSHBEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOSHE MARKOWITZ / NEPHEW 3709 BANCROFT ROAD - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 15 ☐ Other (Specify) KOVNA CONG. 03/01/2006 | BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease of condition resulting in death) 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Onset and Death Physician /Medical **Examiner** candinic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 1 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H31615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wolfer Ave. sect eV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#10a-c.10e-f, perFH, 6853, 3/28/06 TT

State of Maryland / Department of Health and Mental Hygiene 1 1 6 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MALLOY 1530PM JOSEPH FEBRUARY 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS BALTIMORE The JOHNS HOSPITAL CITY If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**X**M 2□F Director July 20,1946 Pennsylvania 191-36-5515 Usual Residence of Decedent 10c. City, Town or Location

MArco Island

Brigantine 10b. County Collier Atlantic 10a. State 10t Florida New Jersey 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 □ No 10e. Street and Number 1271 Ember Court 10f. Zip Code 34145 10g. Citizen of What Country? 121 Hudson Street 238 08203 United States death Funerai Itams 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after l ☐ Yes 2 MNo f Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No þ Specify: Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) Insurance Broker Insurance permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any njury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Malloy Julie Galvin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Malloy, Wife 121 Hudson Drive, Brigantine, New Jersey 08203 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philadelphia Crematories 2/25/06 Philadelphia, PA 21. Signature of Funer Service Licensee 22. Name and Address of Facility Hinski-Tomlinson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appro Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METABOLIC DERANGEMENT /Medical Due to (or as a consequence of): Examiner OBSTRUTION BOWEL Dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed CELL CARCINOMA (LOCALLY ADVANCE) TRANSITIONAL Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) per 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Tes 2 No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 29c. License number MO RES-ØØØ FEBRUARY 21,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER LEARY MD JOHNS HOPKINS HOSPITAL, 600 North WOLFE Street, BALTIMORE, MD 21231 THE 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State 02 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Nelson William Neal, Sr. February 27 2004 0916 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL PONIAULA SALISBURY NICOMICO If Under 1 Year It Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□F Hours 214-18-0552 83 Director DEC 17, 1922 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Directo Maryland Dorchester Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Race Street, P.O. Box 323 21869 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 1943-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heating and Air Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker 10 Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Nicholson Raymond Neal Minna Freda Reuling 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Velma Anita Neal/Wife 209 Race Street, P.O. Box 323, Vienna, MD 21869 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: if its
eny injury or ot
once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/28/06 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signatur of Fur erat Service Licensee M Edward A. 299 Frederick Road Baltimore, MD 21228 Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failute. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ACUTE -IVER Physician DAYS /Medical Due to (or as a consequence of): **Examiner** HEPATOMA 45 DAYS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examin or Attending Physicien: The law requires that the death certificate be executed anding physicien and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the e 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 1 ☐ Yes 2 ☑ No After this 28a. Oate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 5 9 6 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) M. SHIRAZI, M.D. PENIN SULA REGIONAL MEDICAL CENTER. MD21801 31. Date fited (Month, Day, Year) 32. Registrar's Signature State Carole & Registrar MAR 0 2 2006

			For Stata Registrar	State	of Maryla			nt of Healite of Dea		Mental Hyg	iene	6	06276	
			Decedent's Name (First, Middle,	Last)						2. Date of Deat	h		3. Time of Death	
Н	Physici /Medio		Charles G. Ove	rfield						Feb.	27 2	Year 006	9:35 P M	
7	Examir		4a. Facility Name (If not institution,	give street and	number)		4b. City	, Town, or Loca	tion of Death	1	4c. County of Death			
			Stella Maris					Timoniur				ltimo		
1	Funeral			6. Sex 1 <b>∑</b> M 2□ F		s. last birthday) Yrs.	Months Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)	
1,36,	Director		233-03-0941 Usual Residence of Decedent	Α -	86	113.				June 7	1919	WV		
	/land		10a. State 10b. County		10c. (	City, Town or Lo	ocation						10d. Inside City Limits	
	Man Man	to	MD Balt	imore		Reister	stow	n					1 ☐ Yes 3☐ No	
	or 28,	irec	10e. Street and Number				10f. Z	p Code		1	0g. Citizen of V	Vhat Cou	ntry?	
	23a (23a)	aic	306 Cantata Ct.	#135				211	36		USA			
	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "natural", or items 23a or 28s-f ehow event. The Medical Examiner must be notified at	Funeral Director	11. Marital Status	Amed	ecedent Ever in Forces?	U.S. 13.	Was Deci	edent of Hispani ecify Cuban, Me	c Origin? (Si xican, Puert	pecify Yes or No- p Rican, etc.)		e - Ameri k, White,	can Indian, etc.	
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	II Yes,	s 2 □ No Give r Dates:		1 🗆 Yes	2X No Spe	ecify:		Specify	/: \	white	
2-0036	thou stura		15. Decedent			16a. Dece	dent's Usi	ual Occupation			16b. Kind of B	usiness/In	dustry	
212	within 72 ene. then na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade complete	d) a (1-4or 5+)	(Give	kind of w DO NOT	ork done during use retired)	most of wor	king			Machine Co.	
2	d with	E O	11	n/i		Mech	anic			,,	liuules	açııv	laciline co.	
9	be filed ital Hygirid other event,	Bec	17. Father's Name (First, Middle, L	ast)				18. N	Aother's Nan	ne (First, Middle, I	Maiden Suman	ne)		
<u>a</u>		၉	Charles G. Ove	rfield				S	arah	Alice Plu	ies			
Maryland	2 a = 2		19a. Informant's Name/Relationsh		• 6		-			ral Route Number	-			
	s 1 and f Health item 27 other tr		Patricia K. Ove	rtiela/w						Reisters				
Baltimore,	Pages 1 nent of P int: If ite		20a. Method of Disposition  1  Oremation	3 Removal fro	m State	Place of Dispo cemetery, crei				/06	20c. Location -			
	t. Pa rtmer rtant:		4 Donation 5 Other (Sp	7/1	E			emorial			inksbu			
Ba	permit. Pages Department of P important: if its any injury or of once.		21. Signature of Funeral Service L	Tary	M	Ĺ	emmo	n Fune Padon	ral He	ome of D	ulaney ium, M	Vall D 21	ey, Inc. 093	
			23a. Part1. Enter the risease, or o	complications the	it caused the de n each line.	ath. Do not ent	er the mo	de of dying, suc	h as cardiac	or respiratory arm	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final	F	A C	tage	+	Hoho	احصاه د	s Di	5895	9	Months	
	/Medical		disease or condition resulting in death)	a. Jue	to (or as a cons	-		1	1111961				THEMAS	
	Examiner		Sequentially list conditions,	b		- 4								
X &	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a conse	equence of):								
	ecute and Ftran	хап	that initiated events resulting in death) Last	c. Due	to (or as a conse	equence of):								
8760,	death certificate be executed e attending physicien and of for use as the burial-transit					-4-0-100 01/1								
28/	ficate phys	edical		d										
Rox	leath certifii attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of preg						23d. Da	e of deliv	erv	
ň	death e atte d for	iciai	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pre	e birth 2 □Fe egnant at time of		_Ectopic p _ Other (s	pecity)			Mo		Day Year	
O.	t the by the archer	hys	9 Unknown	9□ Un	known									
ŭ.	The law requires that the de tite has been signed by the a bage 2 should be detached I	by P	Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying	cause given in F	Part I.	23e. Did tot	acco use cont	ribute to t	he cause of death?	
ğ	w require been sig should b									1 □ Ye	s 28 No	3 Prot	pabły 4 □Unknown	
Hecords,	law re as be 2 sho	Completed								24a. Was a autops	n 24b. \	Vere auto	opsy findings available impletion of cause of	
		O.								perform	ned?	leath?		
Vital	ctor,	Be (	25. Was case referred to medical examiner?	filen-				26. F	Place of Dea	th Check only on	θ)			
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Ĕ	ding P th. After t funera	ino	27. Manner of Death  1. ■ Natural 5 □ Pending	(M	te of Injury o <i>nth, Day Year)</i>	28b. Time o Injury		28c. Injury at Work?		28d. Describe ho	w injury occurr	ed		
S	tend seath tor: /	cati	2 Accident investig	ot be			М	1 🗆 Yes	2   No	00(1) (0)	- 111 -1			
DIVISION	al or Attendir s after death. Il Diractor: Af id in by the fu	Certification:	4 Homicide determin	ned 286. Piz	ice of Injury - At ilding, etc. <i>(Spe</i>	nome, tarm, str cify)	reet, tacto	ry, office		28f. Location (St. City or Town		er or Hura	ar Houte Number,	
_	spit ours nera fille		29a. Certifier 1 ☑ Certifying	Physician: To	the best of mv k	nowledge, deat	h occurre	d at the time, dat	te and place	and due to the ca	use(s) and ma	nner as s	tated.	
	o the Hos ithin 24 hr o the Fun ompletely	edicai	(Check only 2 Medical E	xaminer: On the	basis of exami anner stated.	nation and/or in	vestigatio	n, in my opinion	, death occu	rred at the time, da	ate and place,	and due to	o the cause(s)	
	within 10 th	Me	29b. Signature and title of certifier	1	11		29	c. License num	ber	2	9d. Date signer	(Month,	Day, Year)	
	c , 1		- mesti	ne V	Yng h	t M	1	DSS	274	0 =	Febru	ary	28 M 201X	
	611		30. Name and address of person v	who completed ca	ause of death (It	em 23a) (Type,	Print)		,		2,31.0			
	2		ERNESTINE WRIG	GHT, M.D	. 2300	DULANE	Y VAI	LLEY ROA	AD TI	MONIUM, I	MD 2109	3		
	Sta		31. Date filed (Month, Day, Year)		. Registrar's Sig	nature	1	28						
	Registr	di l	WUD V	9 2000	43 3	686	100	E						

DHMH 17 Rev 1/2001

FEBRUARY 27, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 23b c per doc 9854 4-13-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Year Rudolph France Overick, Jr. 6:24 AM TEBRUARY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death If Under 24 Hrs.
Hours Min.

12/03/1937 4c. County of Death **Examiner** BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL 6 LEN 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days 68 Yrs 202-32-1053 Director Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worde 7 is marked other than "neturel", or iteme 23a or 28a-f eho traumatic event, the Medical Examinar must be confilled at Director MD 1 ☐Yes 2 🕅 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 King George Dr. 21061 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Amed Forces: 1 MYes 2 □ No If Yes, Give 1963 — Year or Dates: 1965 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rudolph France Overick, Sr. Mary DeFolio 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: if item 27 is eny injury or other trau once. Robin Overick / wife 402 King George Dr Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of West Arunde)
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) 2/18/2006 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ACUTE REMAL FAELURE 0475 /Medical Due to (or as a consequence of) 5 years Cirrhosis Examiner DAYS Securentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequent of) Division of Vital Records. P.O. Box 68760. ettending physicien by Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 小小子 2 No Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Tyes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this : After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17/2006 0060796 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 HOSPITAL DRIVE, GUEN BUNNES, MO WILLIAM MAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2346 Registrar MAR 0 2 2006

DHMH 17 Rev 1/2001

RUDGE-PH

DVERICK

State of Maryland / Department of Health and Mental Hygiene) For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 28, Month **Physician** 2006 10:45A February Anthony Joseph Ossi /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1XM 2□ F 1911 New York 3, 127-12-0621 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nant of Heelth and Mental Hygiene.
sut: If item 27 ie marked other then "natural", or Itema 23a or 28a-f ehow ury or other traumatic event, the Medical Examinar mout be noutified at 1 ☐ Yes 2 X No Bethesda Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 9620 Parkwood Drive 20814 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Amed Forces?

1 ☑ Yes 2 ☐ No 1942— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 1971 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Civil Servant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Teresa Del Favero Ferdinando Ossi 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9620 Parkwood Drive, Bethesda, Maryland 20814 Lucille S. Ossi/Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or of once. Gate of Heaven March 3, 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 2006 Silver Spring, Maryland Cemeterv 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature on uneral Service Licensee Wisconsin Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Meast /Medical Due to (or as a consequence of) Examiner Hial Hhr 100x Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examine anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by Sismoia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown neste 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes this certificate 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D005361) March 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 11125 Rochville Pike, #208, Rochville MD20852 sa than 31. Date filed (Month Day) 32. Aegistrar's Signature State Registrar GORAGE

1045

Ossi, Anthony

State of Maryland / Department of Health and Mental Hygiene

06279

Physicia /Medica Examin

**Funeral** Director

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar		Cei	runcate of t	Jeain	R	ag. No.	00 5 1 2				
1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat	:h	3. Time of Death				
Raymond V. Of					FEB. 2	_	1020 A M				
4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or	Location of Death	4c. County of Death						
ANNE ARUNDEL GE			ANNAPOL	IS If Under 24 Hrs.	O Date of Birth	ANNE AF					
220-16-4214	Sex 7. Age (In yi	rs. last birthday) 77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Apr 25	1928 Ma	irthplace (State or Foreign Country) ryland				
Usual Residence of Decedent	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
Maryland Anne A		Annapo					12 Yes 2 No				
10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (	Country?				
412 Washington	St. Apt C		21403			USA					
11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	spanic Origin? (Sp	ecify Yes or No-		nerican Indian,				
1 ☐ Never Married 2 ☐ Married	1 TXYes 2 □ No				rican, etc./	Black, Wh					
3 ☐ Widowed 4 🗓 Divorced	If Yes, Give Year or Dates: 195	0-52	1□Yes ŽΩNo	Ѕреслу:		Specity: E	Slack				
15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of Busines					
Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	)	9	United	States				
11th	Naval A	cademy									
17. Father's Name (First, Middle, Last				18. Mother's Name		Maiden Surname)					
William H. Offer  Viola Green											
19a. Informant's Name/Relationship (Type, Print) Eleanor M. Greene (Sister)  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State cemetery, crematory or other place)											
											4 Donation 5 Other (Specify) Maryland Veteran 3-1-06 Crownsville, Md.
21. Signature of Funeral Service Licensee  Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401											
23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Ather s	chotic	^	g, such as cardiac	a \ \ \	est,	Approximate Interval Between Onset and Death				
	Due to (or as a cons										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or as a cons	Due to (of as a consequence of).									
resulting in death) Last	Due to (or as a cons	sequence of):									
•	d										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of prediction of predictions of the second of the	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of o	lelivery Day Year				
Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause give	en in Part I.	23e. Did tol	pacco use contribute	to the cause of death?				
in the past 12 months? 1   Yes 2   No 9   Unknown   1   Yes 2   No 3   Probably 4   Unknown   2   Year   Ye											
					24a. Was a autops perform	ned? prior t					
25. Was case referred to medical				26. Place of Deat	h (Check only on	Θ)					
examiner?	Hospital: 1 ☐ Inpatient 2	▼ ER/Outpatie	nt 3 DOA Oth	er: 4 🗌 Nursing Ho	me 5 ☐ Reside	ence 6 Other (Sp	pecify)				
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Wor	vat ⟨? Yes 2 □ No	28d. Describe ho	ow injury occurred					
3 Suicide 6 Could not to determined	De Blace of Injury A	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
27. Manner of Death  1 Natural 2 Accident 3 Suricide 4 Homicide  29a. Certifier (Check only one)  27. Manner of Death 5 Pending investigation 6 Could not to determined	hysicien: To the best of my liminer: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the tin evestigation, in my o	ne, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)				

State Registrar

29b. Signature and title of certifier

Date filed (Month, Day, Year)

THE OD ONE

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

M. King

29c. License number

O.C.M.E

111 PENN STREET, BALTIMORE, MARYLAND 21201

29d. Date signed (Month, Day, Year)

FEB.

24, 2006

			1 - State State Registrar	of Maryland / Department of Health ar Certificate of Death	nd Mental Hygier	2000 00200
	Physici	an	Decedent's Name (First, Middle, Last)	Pinder	2. Date of Death	Day Year 3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give street and	number) 4b. City, Town, or Location of I	Death .	4c. County of Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year   If Under 24		9. Birthplace (State or Foreign
	Director		259 - 56 - 783   1 M 2 1 M   2 M i	Yrs. Months Days Hours	Min. (Month, Day, Yea 05-24-	1924 Florida
	death with the Maryland me 23a or 28a-f ehow f must be nutilled at	Į.	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits* 1 ☐ Yes 2 10 No
ند	ith the Marylar or 28a-f ehow	Direct	10e. Street and Number	101. Zip Code	10g. /	Citizen of What Country?
2	death w	Funeral Director	11. Marital Status 12. Was D	Second Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No-	14. Race - American Indian,
36	nit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla arment of Health and Mentat Hygiene, ordent: if itam 27 is marked other then "natural", or tieme 23s or 28s-f ehov injury or other traumatic event, the Modical Examinar must be notified at in.	by Fur	1 Never Married 2 Married 1 Yes,	d Forces? If Yes, specify Cyban, Mexican, Fest Sylvan, Give 1 □ Yes 2 ☑ No Specify: or Dates:	ruerto Hican, etc.)	Black, White, etc.  Specify:
)A 15-0036	n 72 ho "natur edical	Completed	15. Decedent's Education (Specify only highest grade complete	life. DO NOT use retired)	f working	. Kind of Business/Industry
22	filed withi Hygiene. sther ther	Comp	12 4	ACCOUNTA	nt Si	alvation strmy
Maryland	ould be fil Mental H arked ott	To Be	17. Father's Name (First, Middle, Last).	An An An An An An An An An An An An An A	s Name (First, Middle, Maid	odriguez
Many	s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 is marked other then other traumatic event. The Mental traumatic event.		19a. Informant's Name/Relationship (Type, Print)	Brother 33 LOS Kooles	or Rural Route Number, City	y or Town, State Zip Code)
ore,	Pages 1 ar nent of Hea int: If Itam i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	om State 20b Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or Town, State
altim	permit. Pages Department of Important: If i any injury or o		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	Evans Funeral Chape 1.	Evans Fune	cral chapel relair
ĕ	permi Depa Impo any ii		23a Part 1 Enter the disease or complications th	3 Newfort DR.	FOREST HIL	Approximate
	Physician		shock, or heert failure. List only one cause of Immediate Cause (Final disease or condition	at caused the death. Do not enter the mode of dying, such as 6a on each line. ESDITATULI DISTUSS	rulac or respiratory arrest,	Interval Between Onset and Death
	/Medical Examiner		9.4	to (or as a consequence of):		1
V	ed sit	ulner	cause. Enter Underlying	r (or as a consequence of):		
v 0	cate be executed physiclan and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due	to (or as a consequence of):		
68760,		edical	d			( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )
	The law requires that the death certifi ate hes been signad by the ettending page 2 should be detached for use as	Physiclan/Me	in the past 12 months?	outcome of pregnancy ve birth 2 □ Fetal death 3 □ Ectopic pregnancy egnant at time of death 5 □ Other (specify)		23d. Date of delivery  Month Day Year
P.O. Box	at the de by the	hysic	9 Unknown 9 Ur	nknown		
	quires the signace of the decoration of the deco	ğ	Part II. Other significant conditions contributing to	o death but not resulting in the underlying cause given in Part I.		co use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐Unknown
eco	e law require hes been si je 2 should l	Completed	clostridium difficile	٥	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ital F	ysician: The i	Be Co	Dre-renal azoter 25. Was case referred to medical	Mi a 26. Place o	1 ☐ Yes 2 54 f Death (Check only one)	
Division of Vital Records,	ding Physician: n. After this certifications director,	2	27. Magner of Death 28a. Da	ate of Injury 28b. Time of 28c. Injury at	ing Home 5 Residence	
sion	At ending ir death.	cation	1 Natural 5 Pending 2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Divi	s after of all Directed in by	Certification:	4 Homicide determined 28e. Pl	lace of Injury - At home, larm, street, factory, office uilding, etc. (Specify)	City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Atlanding Phwithin 24 hours after ceath. To the Funaral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Examiner: On th	the best of my knowledge, death occurred at the time, date and le basis of examination and/or investigation, in my opinion, death namer stated.	place, and due to the cause occurred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	7.bec	Date signed (Month, Day, Year)
	4		ap. Name and address of person who completed of	cause of death (Item 23a) (Type, Print)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	2/106
	Sta	te	31. Date filed (Month, Day, Year) 3:	ad MD 9000 Franklin.  2. Registrar's Signature	Square Driv	1e 1201to, MI) 21237
	Registi		MAR 0 2 2006	Library St. Speed		

EM 06-013			Please * Amend item#23e	Type or Print i	n Black Inc E. 2854.4/2	delible In 7/06 TT	k. Ensure A	All Copie	s Are Le	egible.	
ommle	Lee Po	age	1 - State Amend Item #	'State of Mary em #8 PEr FI 20b Per FH (	laing / Depa H G853 3/ 5852 3/62	rtment of	Health and III III I Death	Mental H	reg. No.	06	0 6 2 8
	Physici		1. Decedent's Name (First, Middle, Last	lee Poad	ne			Februa	Day	2006	7:32 A M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of Deat	h		unty of Death	
	Funeral		7300 York Road 5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)	If Under 1 Ye		8. Date of B	irth <b>1941</b>	altimor 9. Birth	e County  place (State or Foreign  ntry)
	Director		249 · lele · lele 93 10	<b>%</b> M 2□F	65 Yrs.	Months Day	ys Hours Mail.	01 . 16	1946		""SC
	ith the Maryland or 28a-f ehow	ctor	10a. State 10b. County Harfo		Edge	cation					10d. Inside City Limits 1 ☐ Yes 2 【 No
	th with th	Dire	1357 Harford	Square	Drive	10f. Zip Cod	21040		10g. Citizer	of What Cou	A
36	er des Iteme	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1Yes _2 No If Yes, Give Year or Dates;	in U.S. 13.	Vas Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No <i>Specify:</i>	Specify Yes or Note Rican, etc.)		Race - Ameri Black, White becify:	
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ivision	r Attendinger death.	Certification:	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☒ Could not be 4 ☐ Homicide	Fnd 2/23/200 28e. Place of Injury building, etc. (5	O6 Fnd 7:1  At home, farm, st  Specify)	5 at reet, factory, off	1 ☐ Yes 2XXXNo	unk 28f. Location City or 1	(Street and I	Number or Rui 7300 Yor	ral Route Number,
۵	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	al Cer	29a. Certifier 1 ☐ Certifying Ph	Found in many sician: To the best of m	edical clir ny knowledge, deal	iiC h occurred at th	ne time, date and place	Towson,	MD ne cause(s) ar	nd manner as	stated.
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	V		30. Name and address of person who	ICA-POLLA	LMD	Print)	Penn Stree	et_Balt:			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Honth **Physician** 510 A M 20 2006 John Francis Parrish /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesap<u>eake Medical Center</u> 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral 1**X M 2 □ F 124-24-3537 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 ie markad other than "natural", or itema 23a or 28a-1 ebov other traumatic event, the Modical Examinar must be notified at 1₽Yes 2□No Director 1041 Halsey St. Brooklyn, N.Y. N.Y. Kings 10e. Street and Number 10g. Citizen of What Country? USA 11207 1041 Halsey Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DRYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. i and 2 should be filed within 72 hours effer of teath and Mental Hygiene. Im 27 is marked other then "naturel", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify:Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Corrections Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther Stiles Walter Parrish, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 476 Clinton Ave. Brooklyn, N.Y. 11238 (SON) <u>Walter Parrish III</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 2006 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any injury or once. Totowa, N.J. Laurel Grove Feb. 28, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee House of Hills Inc. Funeral Home 1000 St. Johns Place Brooklyn, N.Y.11225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arterisclentic Cardiovascular disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ cete has been sign, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed actorensa 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificete has 1 Yes 2 No After this certification Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ■ EP/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number DOD 14-206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLABIRO AVE 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Elizabeth Regland Sebruary 27, 2006 12:574 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 1728 Wad 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Wadsworth Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 M 2 KF Yrs 213-18-4618 Director Maryland Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 15A 21239 728 Wadsworth Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 25 No Specify: 3 Widowed 4 □ Divorced White \*natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'na eny Injury or other traumatic event, Ite Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) Clerk TRI State 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Heinfield Walters August masu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert David Ragland-500 Yakara Road Towson Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Moreland Memorial Fark Parkville Marylax Morch 2, 2006 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Chapel of Memories Harford Road Parkville Mary and 21234 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mounts /Medical Due to (or as a consequence of): Examiner AD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed 47 N Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. perdolesterolemia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death?

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ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Ragland

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o uc	ding Ph After th funeral	ion:	27. Manner of D ath 1 Natural 5 □ Pending		ry y Ye <i>ar)</i>	28b. Time Injury	of 2 M	Bc. Injury Work	rat ⟨? Yes 2 □ l		d. Describe ho	w injury o	occurred	
Division	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investig. 3 Suicide 6 Could n 4 Homicide determine	ot be	ury - At ho c. <i>(Specif</i> )	ome, farm, s			103 2	-	f. Location (St. City or Town		Number or Ru	iral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical Ce	29a. Certifier Certifying	g Physician: To the best examiner: On the basis of	of my kno	wledge, dea	th occurred	at the tim	ne, date an	d place, an	d due to the ca	ause(s) an	nd manner as	stated.
	To the P within 24 To the F complete	Medi	one) 29b. Signature and title of centilier											1. Day, Year) 28 2006
}			Mens					20	)05°	1423	F	obre	cary t	28 2006
	241		11001 504	who completed cause of d	leath (Item	23a) (Type	, Print)	0	10	1.	#	7	0	1.2 = ==
	Sta	ite	31. Date filed (Month, Day, Year)	5 360 Loc 37 Registr	ar's Signa	ture #	VOIVE	) ra	JT 15 K	(ldus	303 /	Ji (1)	nore /	117 51531
	Registi	-	MAR 0 2	2006	1 8	Sp	8464							

			For State Registrar	State of Maryla	-	artment of H			giene	6	0628	36
	K <	*	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	Day	Year	3. Time of	Death
	Physicia /Medic		Raymond Jose	ph Roche, J:	r.			Februar	y 27,	2006	6:05	A M
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of De	eath	4c. Count	y of Death		
			Shady Grove Adv			Rocky				gomer		
	Funeral		5. Social Security Number 6. S	6ex 7. Age (In yrs ▼ M 2□ F 83	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	lin (Month. Da	v Year)	9. Birth	place (State o	or Foreign
	Director		577-24-1982 Usual Residence of Decedent	- 03				July 2	6, 1922	wasni	ngton,	D.C.
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation		-			10d. Inside C	ity Limits
	Mary	ţ	Maryland Montgom	ery	German	town					1 🗌 Yes	2 <b>X</b> No
	r 28a	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	h witi	Funeral Directo	20808 Doxdam Wa	У		208	376		Unite	d Sta	ates	
	deat	ner	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No- uerto Rican, etc.)	- 14. Ra	ce - Ameri	can Indian,	
9	or its		1 ☐ Never Married 2 ☐ Marned		WII	1 ☐ Yes 2 ☑ No	Specify:	,	Speci		nite	
Ö	within 72 hours after death with the Maryland ene. Itan "natural" or itama 23a or 28a-f show ite Medical Examinar musi ka notified at	d by	3 Widowed 4 Divorced		10- 5							
<u>.</u>	"nat	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of	working	16b. Kind of E	susiness/ir	ndustry	
12	withir ene. than	ш	Elementary/Secondary (0-12)	College (1-4or 5+) 4	1	mation Sp		st	Federa	1 Gov	ernmer	nt
0	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last				18. Mother's I	Name (First, Middle,	Maiden Suma	me)		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or itama 23a or 28a-f show aumatic event, it a Maryloa Examinar mant he notified at	To Be	Raymond Joseph Ro	che, Sr.			Genev	ieve O'Co	nnor			
ary.	shound M		19a. Informant's Name/Relationship (		19b. Maili	ing Address (Street	and Number or	Rural Route Numbe	er, City or Town	, State, Zi	p Code)	
	s 1 and 2 should of Health and Men item 27 is marke other traumatic		Kevin J. Roche /	Son	13609	) Lewisdal	le Road	, Clarksb	urg, Ma	ry1ar	ad 2087	71
ē,	of He of He fitem r oth		20a. Method of Disposition	20b.	Place of Disponentery, cre	osition (Name of matory or other place	) Ma	rch 3,	20c. Location	- City or T	own, State	
Ĕ	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Contents)	Hemovaritom State A 1		s Cemeter			Germant	own,	Maryla	and
altimore,	permit. Pages Department of important: If it any injury or o		21. Signature of Funeral Service Lice	nsee /	2 RO	2. Name and Addre	ss of Facility	neral Home/	Rockri 11e	Tro		
m	88188		> Chiperater Sur		1305 30	O West Mont	gomery Av	venue, Rocky	rille, Ma	ryland	20850-	2805
			23a. Part1. Eyer the disease, or com shock, of heart failure. List only	plications that caused the dea	ath. Do not en	ter the mode of dyin	ng, such as care	diac or respiratory a	rrest,		Approximation of the Approxima	
	Physician		Immediate Cause (Final disease or condition			RY ARI					Ponset and	. 1 4
	/Medical		resulting in death)	Due to (or as a conse	quence of):						1 4	
	xaminer		Sequentially list conditions,	b. SEPSIS							1 da	4
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		0.00 10 1	INICK	PATION	1			
	and and trans	хаш	that initiated events resulting in death) Last	Due to (or as a conse		HKDIAL	INFF	ARCTION	J			
760,	Attending Physician: The law requires that the death certificate be executed in death.  sector: After this certificate has been signed by the attending physicien and ector: After this certificate shall be detached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit.	cal E		200 10 (0) 40 4 001100	4401100 017.							
687	phys phys s the			_ d								
×	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. D	ate of deliv	rerv	
P.O. Box	death a atter	clai	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		□Ectopic pregnancy □ Other (specify)	/		M	lonth	Day	Year
o.	that the de led by the a detached f	hys	9 Unknown	9 Unknown								
œ.	es that igned t be det	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying cause giv	en in Part I.	23e. Did t	obacco use cor	ntribute to	the cause of	death?
ğ	w require been sig should b							10`	Yes 2 No	3 🗌 Pro	bably 4 🗌	Unknown
Records,	awre is be 2 sho	plet						24a. Was		Were aut	opsy findings ompletion of a	available
ž	Physician: The lav r this certificate has ral director, page 2 a	Completed							rmed?	death?	2□ No	,4436 01
ita	ian: irtifica ctor,	Be	25. Was case reterred to medical examiner?				26. Place of	Death (Check only o	one)			
<del>_</del>	hysic his ce I dire	2	1 ☐ Yes 2 No		☐ ER/Outpatie		4 🗀 1401311	ng Home 5 ☐ Resi	dence 6 🗆 O	her (Spec	rfy)	
n o	Jing Ph J. After th funeral		27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor	y at	28d. Describe	how injury occu	ırred		
<u>sio</u>	tendi leath. tor: A the fu	catl	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2. No	004 1 4			15	
Division of Vital	or Attendation of Director:	Certification:	4 Homicide determined		home, tarm, st cify)	reet, factory, office		28f. Location (: City or Tox	vn, State)	iber or Hui	ai Houte Nun	1Der,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a, Certifier SCertifying P	hysician: To the best of my kr	nowledge dos	th occurred at the time	me date and o	ace and due to the	causa(s) and a	nanner ac	stated	
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical Exa	miner: On the basis of examinand manner stated.	nation and/or i	nvestigation, in my o	ppinion, death o	occurred at the time,	date and place	, and due	to the cause(	s)
	To the Hospital within 24 hours To the Funeral completely filled	Med	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sign	ed (Month	, Dey, Year)	
)			DANGALLA	1/100 1/10		Do	06312	9	FEBRU	ARY	27,20	006
1	102		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	, Print)						
1	-		PONLIMI NAD	110011	, , , , ,		Rockvi	ille, Mary	land 20	0850		
	Sta		31. Date filed (Month, Day, Year)	32. Pegistrar's Sign	nature							
	Regist	rar	MAR 0 2 2	006 stem.	S. Say	DEMIN						

			Please 1	Type or Pri							-		_	).		
		•	For State Registrar	State of M	arylari		tificate			IIG W	entai my	Reg. N	HIII	06	28	87
	Physici	an	1. Decedent's Name (First, Middle, Last				-				2. Date of D Month		ay Ye	ar .	ime of	
	/Media		Ilene Joan Regall								02	2		5 4:2	ŧ0 a	am M
	Examir	er	4a. Facility Name (If not institution, give	street and number)	•		4b. City, T	own, or	Location of	Death			4c. County of Death			
			Stella Maris 5. Social Security Number 6. Se	v 7 Ac	a (In vrs	last birthday)	Timo If Under		1 If Under 2	4 Hrs.	8. Date of B		altimo	ce Birthplace (	State n	r Foreign
	Funeral Director		,	_М 20ДГ	73	Yrs.		Days	Hours	Min.	(Month, D	ay, Yeai	) M:	arylar	nd	, , orongi,
	9		Usual Residence of Decedent		T						71-31	-195	J			
	anylar ehow	_	10a. State 10b. County			y,TownorLo .timore										ity Limits 2 \( \subseteq No
	the M	Director	MD n/a		рат	CIMOLE	10f. Zip	Codo				100.0	itizen of What		<u> </u>	
	with	급		1										Country		
	ne 23	era	5528 Silverbell F	12. Was Decedent	Ever in U.	.S. 13. 1	212 Was Decede		spanic Orig	in? (Spe	cify Yes or N Rican, etc.)	U.S	. A . 14. Race - A	merican Inc	lian,	
ယ	or iter	by Funeral	1 ☐ Never Married 2万 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give						Puerto F	Rican, etc.)		Black, W			
8	rei', c	l by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1 ☐ Yes 2	A No	Specify:				Specify:	White	2	
21215-0036	within 72 hours after death with the Maryland ane. than "naturel", or iteme 23e or 28e-f ehow he Medical Examiner must be inclilied at	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	=	(Give	dent's Usual kind of work	done a	luring most	of workir	ng	16b.	Kind of Busine	ss/Industry		
121	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or	5+)		<i>po not u</i> se i <b>rd</b> C1		)			н	ospita.	1		
<b>d</b> 2	Hygie Hygie other		17. Father's Name (First, Middle, Last)	1/a		ı wa	itu oi	CIK	18. Mother	's Name	(First, Middle	-		<u> </u>		-
an	ould be Mental arked o	То Ве	Vernon McPherson Evelyn Tuma							ıma						
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Mana	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street ar								Rural Route Number, City or Town, State, Zip Code)					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, the Mardical Examiner mast be neitlied at ODG.		John Regalbuto, S	Sr./Husba						l., E	Baltimo	ore,	MD 2	L206		
Baltimore,	of He		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. P	lace of Dispo emetery, crer	sition (Nam natory or oti	e of her place			ate	20c. l	ocation - City	or Town, S	tate	
Ë	Pag tment tant: jury c		4 ☐ Donation 5 ☐ Other (Specify)		Mt.	01ive			1	2-25-			dallst			
3ali	permit Deper Impor any in once.		21. Signature of Funeral Service Licens	00		22	2. Name and	l Addres	s of Facility	Mill	er-Dip	pe1	Funera		ne	
ī	40244		23a. Part1. Enter the disease, or compl	lications that cause	d the death	h. Do not ent					Baltir		, MD 2		oximate	е
			shock, or head failure. List only o Immediate Cause (Final	ne cause on each I	ine.	n. Do not on	01 1110 111000	, or aying	g, 30011 03 0	<b>Ja</b> 1 <b>G</b> 1 <b>G</b> 0	1 Tospilatory	ui rost,		Inter	val Betv	ween
	Physician /Medical		disease or condition resulting in death)	a. LUNG CA		uence of):								-		
	Examiner				a consequ	<b>u</b> ence or).							Funeral Home MD 21206 Approximate Interval Between Onset and Death			
		ner	Sequentially list conditions, if any, leading to immediate eaute. Enter Undertying Cause (Disease or injury	Due to (or as	a conseq	uence of):										
$\checkmark$	icuted nd transit	aminer	that initiated events	c.												
90	e exe sien a urial-	EX	resulting in death) Last	Due to (or as	a consequ	uence of):										
68760,	cate b	dlca		d												
9 ×	The law requires thet the death certificate be exected has been signed by the ettending physicien and agge 2 should be detached for use as the buriat-the	Physician/Medical	IF FEMALE:	23c. If yes, outcome	of pregna	incv							23d. Date of	deliven		
Box	death e etter d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1⊡Live birth 4⊡Pregnant a			Ectopic pre Other (spe					1	Month	Day	Y	Year
P.O.	thet the dead by the detached	hys	9 Unknown	9□ Unknown		_										
	res the igned be det	by P	Part II. Other significant conditions co	ntributing to death t	out not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did	tobacco	use contribut			
ğ	w require been si should b	ted									1 🗆	Yes 2	2□No 3□	Probably	4 <b>X</b> )U	Jnknown
of Vital Records,	e law n has be je 2 sh	Completed									24a. Wa auto	DOSV	prior	autopsy fir to completi	ndings a	available ause of
<u>=</u>	The cate h	Соп									perf 1 ☐ Yes	ormed? 2 X N	o 1 🗆 🗅	n? /es 2□ N	No	
/ita	sician: The certificate ha	Be	25. Was case referred to medical examiner?	dospital:				I Other			Check only					
5	Physician: this certificatal director, I	10	1 ☐ Yes 2 📉 No 27. Manner of Death	lospital: 1 ☐ Inpati 28a. Date of Inju		ER/Outpatier 28b. Time of			4 LI NUI		ne 5 Res		6 NOther (S	Specify) H	OSP	ICE
5	ding h. After funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	м	Sc. Injury Work	(? Yes 2 □ N		ou. Describe	HOW HIS	ny occumed			
Division	Attender deat	fica	3 Suicide 6 Could not be	28e. Place of In	jury - At ho	ome, farm, str					8f. Location	(Street a	nd Number o	Rural Roul	e Numi	ber,
Ö	s after al Direct ed in by	Certification;	4 ☐ Homicide Getermined	building, e	tc. (Specify	y)					City or To	own, Sta	(6)			
	To the Hospital or Attending Physimithin 24 hours after death.  To the Funeral Director; After this completely filled in by the funeral director.		29a. Certifier 17 Certifying Phy (Check only 2 Medical Exami	sician: To the best	of my kno	wiedge, deat	h occurred a	t the tim	ne, date and pinion, death	d place, a	and due to the	cause(	s) and manner	r as stated.	ause(s	;)
	To the h within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner si	tated.				number				ate signed (M			
	T wil		250. Signature and title of certifier						3725	-			$z/z_3$		cai)	
,			/ / /					- (	2102				-, -	/		

Registrar
DHMH 17 Rev 1/2001

State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

MAR 0 2 2006

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H		, ,	jiene 10. 12. 0 0 6	06288					
	Physicia	20	1. Decedent's Name (First, Middle, Las			14		2. Date of Dea Month	th Day Year	3. Time of Death					
	/Medic				ne Reinha				ıary 28, 2006	12:10 а. м					
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Table 1	aston	4c. County of Death	albot					
	Funeral		5. Social Security Number 6. S	Villiam Hill Mar	1Of e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth		place (State or Foreign					
	Director		197-24-8582	□M 2004.F	75 Yrs.	Months Days	Hours Mir	November 2		ennsylvania					
	pug &		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	cation		TTO VOITIDOT E	1	10d. Inside City Limits					
	Maryli f sho	ō		lbot	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Easton			1 ☐ Yes 2 XNo					
	r 28a-	Director	Maryland Ta  10e. Street and Number	iibot		10f. Zip Code	Lasion	1	log. Citizen of What Cou	untry?					
	th with		501 Dutchmans Lane				21601		U.S	.A.					
	r dear	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	ispanic Origin? ( in, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White						
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 😿 I If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🗹 No	Specify:		Specify:	White					
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Modical Examiner must be notified at		15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occupa	ation		16b. Kind of Business/li						
215	hin 72	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	life.	kind of work done on DO NOT use retired	during most of wi l)	orking	Own	Home					
21	filed wit Hygiene Sther the	Completed		2	,	Housew	ife & Mothe								
and	be fill hd oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,							
Maryland	2 should be and Mental is marked c	ပ္	Florenz J 19a. Informant's Name/Relationship (7	. Donahue	19b Mailir	ng Address (Street :	and Number or F		trude Davin r, City or Town, State, Zi	in Code)					
Ma	nd 2 s lith an 27 is r trau		Mr. James H. Reinhard					aston, Maryla		p dodd)					
altimore,	item 27 l		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or T	own, State					
Ē	Page		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Bonation 5 ☐ Other (Specify			View Cemet		3/04/2006	Marriottsville	e, Maryland					
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Ignatur of uneral Service Lyn	/	22	2. Name and Address	s of Facility	ne. P.A.							
	- 10		Slack Funeral Home, P.A.  3871 Old Columbia Pike Ellicott City, MD 21043  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	Physician		Infrediate Cause (Final	one cause on each li جر	En Lin	enolos D	Hom	malren	7	Intervat Between Onset and Death					
	/Medical		disease or condition resulting in death)	a. Due to (or as,	erconsequence of):	o ver eng	1	1		10 yeary)					
	Examiner		Sequentially list conditions.	b	Drebrow.	as Culen	Dese	6-6		542					
J	pe is	inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					/					
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	CDue to (or as a consequence of):					-						
8760,	cate be executed physicien and the burial-transit	dica! E	· ·	d											
9	rtificat ng phy as th	Medi	IF FEMALE:												
Вох	death certifi e attending id for use as	an/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth		Ectopic pregnancy			23d. Date of deliv	very Day Year					
о. В	that the death certifined by the attending of detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			, worth	Day Da.					
<u>α</u>	The law requires that the te has been signed by th rage 2 should be detache	/ Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?					
Vital Records,	n sign	d by	Hyperlen	n				1 🗆 Y	es 2 No 3 Pro	bably 4 Unknown					
CO	aw requii s been s 2 should	Completed	/ /					24a. Was a		opsy findings available					
R	The law ate has page 2 s	mo						autops perfori 1  Yes	med? death?	ompletion of cause of					
/ita	yelcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					ath (Check only or	16)						
ot \	y sis	2	1 Yes 2 10 27. Mann of Death	Hospitat: 1 ☐ Inpatie			4 Mursing		ence 6 Other (Spec	ify)					
no	ding h. After funer	tion	1	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	Worl	/at ⟨? Yes 2 ∐No	28d. Describe no	ow injury occurred						
Division	l or Attending effer death. Director: Affer in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Int	ury - At home, farm, str				treet and Number or Rui	al Route Number,					
á	s effer at Direct	Certification:	4 Homicide	building, et	c. (Specify)			City or Town	n, State)						
	To the Hospitel or Attending Ph within 24 hours effer death. To the Funerel Director: Affer th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best liner: On the basis of and manner sta	examination and/or inv	n occurred at the tim vestigation, in my of	ne, date and place pinion, death occ	e, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)					
	To the within To the comple	Med	29b. Signature and title of certifier	, / /	^	29c. License	number	2	9d. Date signed (Month	, Pay, Year)					
)	. > - 0		Nollann	Harry	(L)M	7	0871	5	2/22/	06					
	20		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print)	-	in d	0//						
	7		William W	000	と.	Eas	lan	TYIC	21601						
	Sta Registr		31. Date filed (Month, Day, Yeer) MAR 0 2 20	100	ar's Signature	selled	,								

		-	For State Registrar	State of Maryland		irtment of H <i>tificate of I</i>			eže() () ()	06289
7	A STATE		Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		SEYMOUR	Н.		RUBIN		FEBRUARY	<sup>D</sup> 23 2006	7:10 P M
	Examin	_	4a. Facility Name (If not institution, give sta				Location of Death		4c. County of Deat	h
1	8.9	·	7111 PARK HEIGHTS  5. Social Security Number 6. Sex	AVENUE APT. #		BALTIMOF If Under 1 Year	E If Under 24 Hrs.	8 Date of Birth	N/A	hplace (State or Foreign
	Funeral Director			M 2□ F 81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y MAR. 29,	1924 Co	untry) MD
1977			Usual Residence of Decedent							
anylar	ed at	<u>_</u>	10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the M	28a-f	Director	MD N/A  10e, Street and Number		BALI	IMORE 10f. Zip Code		100	. Citizen of What Co	X
With	3a or	ā	7111 PARK HEIGHTS	AVENUE APT	#105	101. 210 0000	21215			USA
death	Items 23a	Funerai		Was Decedent Ever in U.S Armed Forces?		Vas Decedent of H	ispanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	rican Indian,
after	ral', or items 23a or 28a-f eho Examinar must be notified at		1 Never Married 2 Married	1 XYes 2 □ No If Yes, Give Year or Dates: WWI		i Tes, specily Cubs	Specify:	ritoari, etc.)	Specify:	WHITE
should be filed within 72 hours after death with the Maryland	"natural", dical Exa	d by	3   Widowed 4 □ Divorced  15. Decedent's Education		.	lent's Usual Occup	ation	16	ib. Kind of Business/	
in 72	n na	plete	(Specify only highest grade	completed)	(Give	kind of work done of NOT use retired	durina most of worki		io. King of Daginoss	maddi y
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e ile	and Mental Hygiene. In marked other than "nature aumatic event, tra Medical	Bec	17. Father's Name (First, Middle, Last)					(First, Middle, Ma	iden Sumame)	
ould t	Ment arke arke	To	MAX		RUBI		ANNA			BERLIN
N	h and 7 le m	İ	19a. Informant's Name/Relationship (Type LAWRENCE RUBIN /			•			City or Town, State, 2 TIMORE, N	
1 and			20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of			c. Location - City or	
Pages 1	ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other plac CHIZUK P	MUNO 2/26	5/2006	BALTIMO	RE, MD
	Department of Important: If eny injury or once.		21. Signature of Funeral Service Licenses			. Name and Addre			ON & BROS.	
3 8	12 E 2 8		Kolito/c	Lun			TERSTOWN	ROAD - P	KESVILLE.	MD 21208
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. e cause on each line.	Do not ente	er the mode of dyir	ig, such as cardiac (	or respiratory arres	t,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Prostate	Can	cer				Gyears
	xaminer			Due to (or as a consequ	ence of):					·
ų		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
cuted	nd transit	Examiner	that initiated events C.							
be executed	sicien and burial-transit	EX	resulting in death) Last	Due to (or as a consequent	ence of):					
cate	physic the b	dical	d.							
Series	nding use a	n/Me	IF FEMALE:							
death	e atte	=		3c. If yes, outcome of pregnan					23d. Date of de	ivery
۽ (		Ci	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	ivery Day Year
, ta	by th	hysicia	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3⊡ ath 5⊡	Other (specify)			Month	Day Year
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Moπ</sup>02/217/2006 ear **Physician** Edna Mae Reeside 7:35am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chesapeake Hospice House Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 □ M 2 😡 F 75 214-44-2490 Director 9/15/30 MD Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other then "naturel", or iteme 23a or 28e-f show treumetic event, it e Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Director N/A MD Baltimore City 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 1825 Jackson Street 21230 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ty∑twever Married 2 Married 1 ☐ Yes 2€ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: white Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) t. Pages 1 and 2 snow. Liferent of Health and Mental Histories 11 in marked of snews 11 Henry Reeside Lelia House 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1825 Jackson Street, Baltimore MD 21230 Linda L. Zollars / Niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Cedar Hill Cem. Glen Bernie MD 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or 2000e. 02/24/06 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor Boda Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) molongio carcinoma **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Physician/Medical Examiner the death certificate be executed the burial-transit Due to (or as a consequence of): use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 □Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No. 3 Probably 4 Unknown Be Completed Cardiarmento Dise 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examine Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Pother (Specify) \ 1050, 05, 0 To 1 Yes 2 No 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospitel or Attending 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation after death Director: 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 | Homicide 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 24 and manner stated 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 02/21/06 1776 50 5 and address of person who completed cause of death (Item 23a) (Type, Print) Annapolo Rd. Bultimora MD 21227 eci 4000 mo 110 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2006

Please Type or Print in	Black Indelible Ink.	Ensure All Copie	s Are Legible

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 26 **Physician** 2006 Margaret Estelle Ricks Russell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT OXFORD 106 RIVERVIEW AVE. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 □ M 2 🖸 F 91 219-05-9835 Yrs. Sept. 04, 1914 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 Ia marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, if a Macdical Examinar must be notified at Talbot Oxford MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21654 USA 106 Riverview Ave. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Ia marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Piece Worker Western Electric 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Hubbard P. Roy Ricks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 la any injury or other tratonce. 106 Riverview Ave. Oxford, MD 21654 Clarence Russell / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/02/06 Metro Crematory Catonsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Funeral Service Licensee 22. Name and Address of Facility
L. Kaufinan Funeral. Home at Meadowriche Memorial Park, IV. 7250 Washington Blvd. Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician wear Laca mich /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to interediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by filled in by the funeral director, page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29c. License number 29b. Signature and title of confifier 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 508 CARELYN HELMLY 32. Segistrar's Signature 31. Date filed (Month, Dey, State Registrar 2006

			1 - For State Registrar	State	of Ma	rylan		artmen rtificat			and M	lental H	ygiei Reg. 1	200	6	06292
æ	Physici	an	Decedent's Name (First, Middle,	Last)								2. Date of D	_	Day	Year	3. Time of Death
	Physici /Medio		Dorothy E.									Februa			006_	9:05 A <sup>M</sup>
12	Examir	er	4a. Facility Name (If not institution,	3	i nu <i>mber)</i>			4b. City,		Location of	of Death			4c. County		
- 45 A			Mt. Claire  5. Social Security Number	Manor 6. Sex	7. Age	(In vrs.	last birthday)	If Under	Ful 1 Year	If Under	24 Hrs.	8. Date of B	lirth		ward	lace (State or Foreign
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کّ	should nd Me mark mark	ဥ	19a. Informant's Name/Relationsh				19b. Mailir	ng Address	(Street a			al Route Num		y or Town,	State, Zip	Code)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** February Baby Boy Scott 2006 17:12 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore Lift Under 1 Year | If Under 24 Hrs. altimo ITV HCDKins. Johns Birthplace (State or Foreign Country) 8 Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Min. Days 1∏M 2□F Hours Months Yrs. Maryland Jan 28, 2006 Director none Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County worle i Health and Mental Hygiene. Item 27 is marked other then "nature!", or Iteme 23a or 28a-1 show other traumatic event, the Modical Examinar must be notified at 1√ Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1826 N. Rutland Avenue 21213 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No II Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education unk unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk Pages 1 and 2 should be Arionne Scott ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> permit. Pages Department of Important: If it eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 NOther (Specify) in state State Anatomy Board 655 W. B

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** B Streptococcal days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ Yo 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes b autopsy 1 Yes 2 No : After this certifical funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident death. 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760. n 24 hours after death.

• Funeral Director: A pletely filled in by the fu within 24 hor To the Fune

To the

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Unn-Ture

ohav mD 32. Registrar's Signature 0

Young

30. Name and address of person who ple cau of death (Item 23a) (Type, Print)

MO

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0056086

Wolfe

29d. Date signed (Month, Day, Year)

February 01, 2006

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20	Funeral Director		3/9-48-3/6/	7. Age (In 7.4) 7. Age (In 7.4)	yrs. last birthday) Yrs.	If Under 1 Ye Months Da			, Year)	Birthplace (State or Foreign Country) ashington DC
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	with the N a or 28a-1	Direct	10e. Street and Number 11546 Stewart Lan			10f. Zip Cod			10g. Citizen of Wha	at Country?
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	Funeral		5. Social Security Number 6. S	lex 7. Ag □M 2. 1 T		last birthday) Yrs.	If Under Months	Days	If Under Hours	Min	8. Date of Bi (Month, Da	av. Year)	22/	Coun	lace (State or try)	r Foreign
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<u>≅</u>	nd 2 shoulth and 27 is mu		George Stephenson				-				harlot					28277
ē,	Hea Hea Hea Hea Hea		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crea	osition (Nar	ne of		D	ate			City or To		
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Baltimore,			21. Signature of Funeral Service Licer													
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	Physician		Immediate Cause (Final disease or condition	0.000	3 0 C	11.10	110			11.	ire				Onset and D	Death
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o.	es that the death certific igned by the ettending p be detached for use as	Physician/Med	1 ☐ Yes 2 ② No 9 ☐ Unknown	9□ Unknown		, out.,	_ 0.1.01 (3)	,00my) <u> </u>								
۵.	that led by deta		Part II. Other significent conditions	contributing to death t	out not res	ulting in the u	ınderlying o	ause givi	en in Part I	l.	23e. Did	tobacco	use cont	nbute to th	ne cause of d	eath?
Records,	uires sigr	d by									1 🗆	Yes 2	No	3 Prob	ably 4	Inknown
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Re	he lav e has age 2	E C									perl	opsy formed?		death?	mpletion of ca	ause of
ā	ician: Th certificate ector, pag	Ö	25. Was case referred to medical						26. Place	e of Death	1 Yes	one)	D	1 ∐ Yes	ZYNU	
of Vital		To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 🔀	NER/Outpatie	nt 3 🗆 D0	Oth	05		me 5□Res		6 □Oth	er (Specif	y)	
0	g Phys er this eral di		27. Manner of Death	28a. Date of Inju	ury av Year)	28b. Time o	of 2	28c. Injun Wor	y at	:	28d. Describe	how inju	ry occur	red		
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer.															
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	To the ! within 2. To the I	Med	29b. Signature and title of certifier	and manner st	tated.		29	c Licens	e number			29d D:	ate signe	d /Month	Day, Year)	
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1	0		30. Name and address of person who	completed cause of	ueath (Ite)	11 23a) (Type.	, Print) صما: -		1-0	سا سد ص	20 0	colo	11'.	~	020	254
ş	St	ate	31. Date filed (Month, Day, Year)	32. Hegist	trar's Sign	ature	سعا (رو	~   ~	-661	CT K	1 10	~ (K)	0,110	- IV	(1) 50	. 500
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			For State Registrar	State o	of Maryla		artment of I	Health and N		giene	16	06296
	·		Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath		3. Time of Death
	Physicia		George E	dward Su	tton, S	r.			Month Februar	y 27,	2006	1:10 A <sup>M</sup>
	/Medic Examin	_	4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town,	or Location of Death		-	ity of Deal	th
		٥.	Genesis College	e View C	enter		Frede	erick		Fr	ederi	ick
. 8	Funeral			3. Sex 1 <b>X</b> M 2 ☐ F		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Ye <i>ar)</i>	9. Birt	thplace (State or Foreign buntry) t Virginia
	Director		579-34-0506 Usual Residence of Decedent	1A1 M 2C1	76	Yrs.			Jan. 1	3, 1930	Wes	t Virginia
and	* =		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
Mary	e de	to	Maryland Freder	ick	F	rederic	k					1XYes 2 □ No
the che	r 288	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Co	ountry?
5 X	23a c	a	701 Angelwing L	ane			2170	3		Unit	ed S	tates
r dea	S III	Funeral	11. Marital Status	Armod E	edent Ever in l	U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (S can, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. R	ace - Ame	erican Indian, te, etc.
s afte	or	by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 X Yes If Yes, G Year or E	<sup>2 □ No</sup> 19	47 <u>-</u>	1□Yes 2XINo	Specify:		Spec	cify:	White
Pours Pours	itural E E		15. Decedent's		7a(85. I)	1	dent's Usual Occu	pation		16b. Kind of	Business	/Industry
<b>1.</b> In 1.	n "na	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor	rking			,
	giene ar tha the	Completed	12	College (	1-401 34)	P	roduce M	anager		C	Froce	ry
ITIO 2 IZ 13-0030 be filled within 72 hours after death with the Maryland	al Hy d oth	Be (	17. Father's Name (First, Middle, L.					18. Mother's Nan			ame)	
should	Ment arke	ပို	Weldon E. Sutto						d D. Max			
- 0	t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	- 1	19a. Informant's Name/Relationshi			1	1350	t and Number or Ru				
<b>6, ≥</b>	Healt am 2 ther		George E. Sutto:	n, Jr. /	Son 20b.	Place of Dispo	sition (Name of	eld Court				5034 Town, State
Pages	Department of Health a Important: if Itam 27 is any injury or other tra		1 Burial 2 Cremation		State	cemetery, cree Park	matory`or other pla cLawn		ch 4,			Maryland
Dallillor	ortan ortan injur		4 □ Donation 5 🛣 Other (Special Service Li		ent	Memoria 22						
	Depa Impo any ir		► MANARAL	DUX	M0142	0 30	bert A. Pu O West Mor	ess of Facility mphrey Fune: ateomery Avi	ral Home/I enue. Rocl	Rockvill sville.	e, Ind Marvla	e. and 20850-2805
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o / o U,	physician and the burial-transit	dicai E										
ilicate	g phy as the	edic		0.								
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C C	he att	Physician/Me	in the past 12 months?  1  Yes 2 No		nant at time of		Other (specify)	-7			Month	Day Year
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The law requires that the death certificate be executed	been signed by the attending p should be detached for use as	by	Pai(II. Other significant condition	is continuating to t	eath out not re	solulig in the d	ildeliyilig cadse gi	IVBITITE CITT.		res 22No		robably 4 Unknown
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DIVISION or Attending	irect n by t	Certification;	3 Suicide 6 Could no 4 Homicide determin	288. Flat	e of fnjury - At ling, etc. <i>(Spe</i> d	home, farm, str cify)	reet, factory, office		28f. Location (. City or To	Street and Nu vn, State)	nber or R	ural Route Number,
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HOH	within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	edical		xaminer: On the i				time, date and place opinion, death occu				
To the	To the	Me	29b. Signature and title of certifier				29c. Licen	ise number		29d. Date sig	ned (Mon	th, Day, Year)
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H	19		30. Name and address of person w		ise of death (Ite	em 23a) (Type,		71	1			
1	i		Hemen Shah M.				n Drive,	Frederic	k, Maryl	and 2	1702	
13	Sta Registr		31. Date filed (Month, Day, Year) MAR 02	2006 32.	Registrar's Sig	nature	Comalle 1					
1	riegistr	aı		-000	ON SOLE	10 10	No.					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician Daniel Richard Stretmater** 8:05P.M February 21, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** West Friendship Howard 3235 Rosemary Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Director 220-56-9763 March 28, 1951 Washington DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or itams 23a or 28a-f show Examiner rount be notified at 1 Yes 2 No Directo Maryland Montgomery **Damascus** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 U.S.A. Funeral 10011 Shelldrake Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White "natural" Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) elecommunications Ineman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Helen McCandless Daniel Joseph Stretmater 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mr. Dan Stretmater
20a. Method of Disposition 3144 Gracefield Rd. Apt. #328 Silver Spring, Maryland 20904 Father t: if item ? 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department important: if injury 02/27/2006 Clarksville, Maryland St. Louis Cometery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JUNEAN MOROB Slack Funeral Home, P.A. 23a. Part1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as carriac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final adenocarcinoma of METUSTATIC Physician 12 mout la disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and al-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-f Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Tunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? this certificate 1 Yes 2X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: RESCHACE After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu/a and title of certifie who completed cause of death (Item 23a) (Type, Print) 8 VILLIUMS 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2006

			1 - For State Registrer	State of Maryland	d / Depart		lealth and	Mental Hyg	iene <sub>eg.</sub> Ño.	06298
	Physici	ań	1. Decedent's Name (First, Middle Last	SMAZ	1 1/224	_		2. Date of Dear	Day Yea	3. Time of Death
J.	/Medic	al	4a. Facility Name (If not institution, give				Location of Dea		12 20 4c. County of D	
	Examin		Anne Arundel Med			-	polis		Anne A	
Vi.	Funeral Director		5. Social Security Number 6. Sec 216-36-8586	x 7. Age (In yrs. Ia	ast birthday) I	f Under 1 Year flonths Days	-		3 <sup>Year)</sup> 940 M	Birthplace (State or Foreign Country) aryland
Marviand	fed al	to	Usual Residence of Decedent  10a. State 10b. County Maryland Anne Ar		Town or Locat	_				10d. Inside City Limits  N Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y
th with the	23a or 28a	al Director	10e. Street and Number 940 President S	St. Apt A4		10f. Zip Code 21403		1	0g. Citizen of What USA	Country?
5-0036 72 hours after death with the Maryland	ital Hygiene. id other than "naturel", or iteme 23a or 28a-f ehow event, itte Medical Examiner must be multiad al.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 XDivorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:			ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify: I	
1215-0 within 72 ha	ne. han "natul s Mudical	Completed	15. Decedent's Edu (Specify only highest grad	de completed)  College (1-4or 5+)		t's Usual Occup d of work done o NOT use retired tracto:	ation during most of wo		16b. Kind of Busine Reliable Company	ss/Industry Contractor
Maryland 21215-0036		To Be Co	10th  17. Father's Name (First, Middle, Last)  Isaac Brown	0	3011	014600	18. Mother's Na	me (First, Middle, i	Maiden Sumame)	
, Mary	aith and Mer n 27 is marke er traumatic		19a. Informant's Name/Relationship (7) Shelly Galloway	(Daughter)	18 Mo	nument			, City or Town, State , Md . 21	
Baltimore,	ment of Heali lant: If Item 2 jury or other		20a. Method of Disposition  ¶□Burial 2 □ Cremation 3 □F 4 □ Donation 5 □ Other (Specify)	Removal from State Bes Par	ace of Disposition emetery, cremate tgate k	on (Name of ory or other place Memori	al 3/		20c. Location · City	
Balt	Departn Importa any nju		21. Signature of Funeral Service Licens	eese MOO 483	82 82	· Rees 1 West	ss of Eacility Sor St. Ar	s Mortu napolis	ary, P. <i>l</i> , Md. 21	A. 401
A 33	nysician Medical		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ	Sat	ine mode of dyin	olon	Cov	est,	Approximate Interval Between Onset and Death
760, specular	S C	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequ  c. Due to (or as a consequ  d.						
O. Box 68.	by the attending phy tached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1  Live birth 2  Fetal 4  Pregnant at time of de 9  Unknown	death 3 Ec	etopic pregnancy ther (specify)			23d. Date of Month	delivery Day Year
م ق	been signed by	by P	Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the unde	erlying cause giv	en in Part I.	23e. Did to		e to the cause of death?  Probably 4 Junknown
		Completed			·			24a. Was a autops perform	ry prior death	autopsy findings available to completion of cause of ? 'es 2 No
of Vita	certificete irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		l Cth	or:	ath Check only on		
o å		tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Inpatient 2	ER/Outpatient 28b. Time of Injury	3 DOA Cth 28c. Injur Wor M 1	y at	T	ence 6 Other (Sow injury occurred	pecify)
5 8	s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, street	, factory, office		28f. Location (Si City or Town		Rural Route Number,
] the Hospital	is ele	Medical (	(Check only 2 Medical Exami	vsician: To the best of my knov iner: On the basis of examinati and manner stated.	wledge, death or ion and/or inves	stigation, in my o	pinion, death occ	urred at the time, d	ate and place, and o	tue to the cause(s)
, and		2	29b. Signature and title of celtifier	Herty	m D	29c. Licens	2143	8	9d. Date signed (Me Feb 2	NAPULIS MOUY
4.	'}\	10.	30. Name and address of pers who can be seen and address of pers who can be seen and address of pers who can be seen address of person address	completed douse of death (Item  32. Registrar's Signat	44		EXENS	E HIGH	WAY A	NAPOLIS MODIY
	Regist		MAR 0 2 200	En En	1 out	2				

		•	For State Registrar	State of M	larylan		artment o			and M	ental Hy	giene Rag. No.	0.0	6	06299
	Physici	an	1. Decedent's Name (First, Middle, La	•					-		2. Date of De Month	Day		ear	3. Time of Death
	/Medic	al	Betty Lee Tre		rl		4b. City, Tov	vn orlo	ocation o	of Death	02	27	200 County of	_	14:15 P.M.
	Examin	er	Proposition Roma	ol Madi		MALL	40. Oky, 100	.5/1	1/13	hurli	/		11		nico
	Funeral		5. Social Security Number 6. S	Sex 7. A		last birthday)	If Under 1 Y		Under	24 Hrs.	8. Date of Bi	rth Voorl	9		lace (State or Foreign
	Director		214-24-4533	I□M 2∑F		77 Yrs.	Months D	ays   h	Hours	Min.	8. Date of Bi (Month, D June 1	7, 1	928	Mar	y1and
	D *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							11	0d. Inside City Limits
	sho	5			100. 010									"	1 ☐ Yes 2 ☑ No
	the M	Directo	Maryland Worcest  10e. Street and Number	er		Uce	an City					10a Citiz	zen of Wh	at Coun	
	with	흐	913 Edgewater Av	onuo			101. 2.00	218	/12			.og. om	USA		.,.
	me 2%	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.	.S. 13.	Vas Decedent f Yes, specify			gin? (Spe	cify Yes or N	o- 1	4. Race -		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, I'm Madical Examinar must be multiled at Once.	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates:	1No		r Yes, specify I□Yes 2🏋		Mexican Specify:	, Puerto I	Hican, etc.)		Black, Specify:	white, o Whi	
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	ient's Usual O	ccupatio	on ina most	of working	na	16b. Kir	nd of Busin	ness/Inc	lustry
21	ithin 16.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work d DO NOT use ri memakei		gost	01 11011111	,9		^		
2	ited w tygier her ti	S	12   17. Father's Name (First, Middle, Last			110		-	Motho	r'e Nama	(First, Middle	Maidan	Own	HOM	e
anc	ntal Hed of	Be	Orastus Minnick					10			Zink	, Maioerr	Surrame)		
Ž	should nd Me mark matic	10	19a. Informant's Name/Relationship			19b. Mailir	ng Address (St	reet and				er. City or	Town, St	ate. Zip	Code)
<b>S</b>	nd 2 suith ar lith ar 27 ls r trau		M. Courtney Treut				olstov								
ē	s 1 ar		20a. Method of Disposition		20b. P	- I have been a second	sition (Name on natory or other		1		ate	4	cation - Ci		
Ē	Page nent o int: If		1 ∑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		8	rraine		p.400)	10	03/03	3/06	Woo	odlaw	m. l	Maryland
Baltimore, Maryland 21215-0036	permit. Departn imports eny inju		21. Signature of Funeral Service Dice Inomas Gregor	nsee	15.00	22	. Name and A	ddress of Fur	of Facility	al Ho	me P.A			- 22	land 21228
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	ed the deat								10, 1	iciry.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			reym	· · · · · ·								Onset and Death
	/Medical		resulting in death)	Due to (or a	s a conseq	uence of):									
	Examiner	_	Sequentially list conditions,	b	Palr	nind.	4	7	610	2.20					
1/	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	5 a conseq	usnos oty.	*			-3					
V	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):									
§ 8760	sicier sicier burii	dicai E		d										M	
(y) (g)		edi		<u> </u>											
0. Box	law requires that the death certific as been signed by the atlending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic pregn Other (specif					2	3d. Date o		ry Day Year
1 9.	hat the		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying caus	e given i	in Part I.		23e. Did	tobacco u	se contribi	ute to th	e cause of death?
ds,	signe d be	d by	Cardian	-			, ,	,			1 🗆	Yes 2	□No 3	☐ Prob	ably 4 Unknown
reuth 314 Vital Records,	w require been si should l	Completed		1.6.11							24a. Was	an	24b We	re autor	osy findings available
Re 7	sician: The lav certificate has rector, page 2	d L									auto perf	psy ormed?	dea	ith?	osy findings available inpletion of cause of
euth Vital R	an: T tificat tor, pa	Be C	25. Was case referred to medical					26	6. Place	of Death	1 Yes	2 No	1	Yes	2 □ No
/ Z =	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat	tient 2	ER/Outpatier	t 3 DOA				ne 5□Res		G □Other	(Specify	)
jo to	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury ay Year)	28b. Time of Injury	28c.	Injury at Work?			8d. Describe				
%	Attending r death.	catic	2 ☐ Accident investigation	n			М	1 🗌 Yes							
$\%$ # $\gamma$ Division	i or Attene efter deatl Director: I in by the	Certification:	3 Suicide 6 Could not t 4 Homicide determined	286. Place of II	njury - At ho etc. <i>(Specif</i> )	ome, farm, str y)	eet, factory, of	fice		2	28f. Location City or To	Street and wn, State)	d Number	or Rura	l Route Number,
a	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Cartifying P	hysician: To the bes	of my kno	wledge, death	n occurred at the	ne time,	date an	d place, a	and due to the	cause(s)	and mann	er as st	ated.
	To the I within 2 To the I complet	Medical	one) 29b. Signature and title of certifier	and manner s	stated.			cense nu			1				Day, Year)
	P P O		by Organizate and the Organization		nan a sa pagamaga an a mana da sa Balangan dan			^		115		2)	27/7	96	
	6		30. Name and address of person who		death (Item	n 23a) (Type,	Print)	_ /	. /.	•		, , , , ,			
	Sta	te	Jr. Steven H	20 rne /	trar's Signa	(arrol	( >7 )	ali	5 BU	4.	MD 2	1801			
1	Registr		MAR 0 2 2006	Para de la constante	M. A	Goods	<u>a</u>								
	MH 17 Pay 1/2		THE THE PARTY OF T	Alexander of the second		1					-				

			1 - For State Registrar	State of Mar		partment of Hertificate of I				ene	5 06300
			1. Decedent's Name (First, Middle, Las	t)					Date of Death	1	3. Time of Death
	Physicia		Joseph	Не	nry	Tho	mas	Jr, F	elruary	-28 20	06 1:25 A M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	r Location	of Death	0	4c. County of	Death
			Keswick Nursing	Home		Baltim					
	Funeral		5. Social Security Number 6. S	7. Age	(In yrs. last birthda	y) If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. 8. Min.	. Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
ш	Director		212-30-6070	ÇIM ZUF	72 Yrs.				05 16		MD
	w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location					10d. Inside City Limits
	lanyla sho	ŏ	MD NA		Baltim						1 XYes 2 ☐ No
	28a-1	ect	10e. Street and Number			10f. Zip Code			10	g. Citizen of Wha	at Country?
	with	2		Dr	T-737 7		212	10		U.S.	•
	eath	era	505 West Univer	12. Was Decedent Ev					fy Yes or No-	14. Race -	American Indian,
·0	r Itar	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give					can, etc.)		White, etc.
සි	al', o	ام ا	3 XWidowed 4 ☐ Divorced	If <b>Ye</b> s, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify	<b>y</b> :		Specify:	Black
9	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show dicul Evar, it at must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dec	edent's Usual Occup	ation	st of working	1	6b. Kind of Busin	ness/Industry
2	within one.	npie	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use retired	1)	3			
7	e filed within at Hygiene. other than 'vant, I'c Me	Cor	12th grade	7yrs		Lawyer	40.14.4		Circh Adiddle A	Priv	ate
Maryland 21215-0036	be fil ta! H d otf	Be	17. Father's Name (First, Middle, Last)							laiden Surname)	
<u>ya</u>	should be nd Mental marked o	မ	Joseph A. Thom		1			via R		O:	. 7. 0 ()
Jar	l 2 sh and ris m		19a. Informant's Name/Relationship (			iling Address (Street				-	
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, if a Medical Ever it or mast be notified at		Donna Harper-D	aughter	5 A 20b. Place of Dis		TO	Dat		Oc. Location - Cit	2 Canada
0	it of h		1 Burial 2 XCremation 3	Removal from State	cemetery, ci	ematory or other plac			- 4		
ij	t. Pa tmen tant: njury		`4 □Donation 5 □ Other (Specify		,	rematory			T/06 E	saltimo:	re, Ma
Baltimore,	permit. Pages 'Department of H Important: If Its any injury or of once.		21. Survey of Funeral Service Licen	C Full	1/0 4	22. Name and Addre arch F/H 300 Waba	sh A	Ave,			
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each line	he death. Do not e	inter the mode of dyin	ig, such a	s cardiac or r	espiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician		1 mediate Cause (Final sease or condition	Tetast	atic pr	DStake C	ane	cer			2 years
	/Medical	1	resulting in death)	Due to (or as a	consequence of):						
Н	Examiner		Sequentially list conditions,	b							
	sit ad	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a	сопѕециелсе оі):						
	cate be executed obysician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequence of):						
8760,	cian cian ourial			000 10 (01 00 0	501155 <b>42</b> 51155 51).						
87	physi the	dica		. d				· · · · · · · · · · · · · · · · · · ·			
9 ×	death certificate be executed e ettending physician and od for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcome o	foregnancy					23d. Date of	of delivery
Вох	etten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death	☐ Ectopic pregnancy	1			Month	
o.	he de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ino or dount	- Cartor (appeary)					
٦.	that the de led by the e		Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	en in Part	t I.	23e. Did tob	acco use contribu	ute to the cause of death?
Vital Records,	w requires t been signe should be	d by							1 🗆 Ye	s 2 No 3	☐ Probably 4 ☐Unknown
Ö	v req beer shou	Completed							24a. Was an	24b. We	re autopsy findings available
Re	has has	d L							autopsy perform	prio dea	or to completion of cause of auth?
a	ician: Th certificate ector, pag	e Co	25. Was case referred to medical				OC Plac	as of Dooth (	1 ☐ Yes 2 Check only one		Yes 2□No
⋚		o Be	examiner?	Hospital:	t 2 ER/Outpat	ent 3 DOA Oth	or		-	nce 6 Other	(Specify)
of		-	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injur		The Part of the Pa		w injury occurred	
on	th. : After s funer	tio	1 Matural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		κ? Yes 2[	□No			
Division	or Attending after death. Diractor: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	y - At home, farm,	street, factory, office	-	281	f. Location (Str City or Town,		or Rural Route Number,
Ö	- 8	Certification:	4   Homicide	Building, etc.	(Specify)				Only or TOWN	State)	
	To the Hospitel or within 24 hours af To the Funaral D completely filled in	edicai (		ysician: To the best of niner: On the basis of and manner state	examination and/or						
	To the within 2 To tha comple	₩	29b. Signature and title of certifier	-		29c. Licens	e number	T	29	d. Date signed (/	Month, Day, Year)
-	F > F 0		M Babelle T	Tac Gre	an safe	0134	657	,	F	ebruary	y 28, 2006
	XI		30. Name and address of person who	completed cause of d	ath (Item 23a) (Typ	e, Print)	EET,	BALT	TOTORE	, M) 2	y 28,2006 1211
	Sta Registi		31. Date filed (Month, Day, Year)	32. Redistrai	's Signature	A STATE OF THE PARTY OF THE PAR					
		الازرو		The Control of the Co	cause of a	-					

		•	For State Registrar	State o	f Marylan	•	artment of F	Health and N Death		giene Reg. No.	006	06301
	Physici		Decedent's Name (First, Middle		T PHIL	IP WE	TZEL		2. Date of Dea Month Februa	ath Day	Year 2006	3. Time of Death
0	/Medio Examin		4a. Fecility Name (If not institution GREATER BALT]			ITER	4b. City, Town, o	or Location of Death		4c. Cou	inty of Death	
	Funeral Director		5. Social Security Number 219-12-9083	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 8	last birthday) 31 Yrs.	If Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 9 / 27 /	y, Year)	Cour	place (State or Foreign http) TLAND
カ ス	the Maryland 28a-f ehow notified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD CITY		10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits 1 Yes 2 No
OBER	after death with the Maryla or Itame 23a or 28a-f ehoi infrerMat be notified at	Funeral Director	10e. Street and Number 6100 MEADOW	AVE.			10f. Zip Code 212	07		10g. Citizen USA	of What Cour	ntry?
) ) )	40	by Funer	11. Marital Status  1 □ Never Married 2 ◯ Marri 3 □ Widowed 4 □ Divorced	Armed Fo	2   No		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, acify: WHI	etc.
215-0036	hin 72 Br. "nat	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Give	DO NOT use retire	during most of word d)			of Business/In	•
and 21	be filed tal Hygi d other event, I	Be	1 2 17. Father's Name (First, Middle, O		ETZEL		REPA	18. Mother's Nam		Maiden Sun	name)	V
Maryl	nd 2 shou lith and M 27 ie mar r traumat	<b>1</b>	19a. Informant's Name/Relationsl DOROTHY M. W		WIFE		•	and Number or Ru				207
WE Baltimore,	Pages 1 all nent of Hea ant: If Item ury or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	pecify)	State	emetery, crer VIDEN		ETERY 3/		KEMPT	on - City or To	MD
Balt	permit. Pages Department of Important: If I any injury or o		21. Signature of Funeral Service			25	4 E. MA	ess of Facility FI	WESTMI	NSTER		21157
68760, <	Chysicien and hysicien and physicien and physicien and physicien and substitutions it is the purial-transit	edical Examiner	23a. Spant. 5—r the disease, or spack, or heart lailure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a consequence of the cons	uence of):	er the mode of dyn	ig, such as cardiac	or respiratory an	1051,		Approximate interval Between Onset and Death
Вох	Attending Physicien: The law requires that the death certific ir death. If death. Sector: After this certificate has been signed by the ettending p. by the tuneral director, page 2 should be detached for use as by the tuneral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live b	tcome of pregna birth 2 Fetel nant at time of di own	Ideath 3	Ectopic pregnance Other (specify)	у		23d.	Date of delive Month	ery Day Year
rds, P	w requires thet the de been signed by the o should be detached	ed by PI	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.			contribute to the	he cause of death? Dably 4 Unknown
Division of Vital Records, P.O.	sicien: The law re certificete has bee irector, page 2 sho	Complet							24a. Was autop perfo 1 \( \text{Yes} \)		b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
f Vita	ysicien: is certific director,	To Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatien	at 3□ DOA Ott	26. Place of Dea ner: 4 ☐ Nursing H	ith (Check only o		Other (Specif	(y)
sion o	utending Physideath. death. ctor: After this / the funeral di	Certification:	27. Manner of Death  1 Natural 5 Pendin  2 Accident investig  3 Suicide 6 Could r	g 28a. Date (Moni	of Injury th, Day Year)	28b. Time of Injury	M 1	ryat rk? ]Yes 2 □ No	28d. Describe h			
Divis	To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	I Certifi	4 Homicide determ	ined 286. Place buildi	ing, etc. (Specifi	v)	eet, factory, office		City or Tou	vn, State)		al Route Number,
	To the Hos within 24 ho To the Fun completely i	Medical	(Check only one)  2 Medical  29b. Signature and title of certifier	g Physician: To the Examiner: On the band mani	asis of examina ner stated.	tion and/or in	vestigation, in my o	opinion, death occu	rred at the time,	date and pla	manner as s ce, and due to gned (Month.	o the cause(s)
	411		Se ET	who complet us	se of death (Item	1 23a) (Tvoe	DZ Print) =	2521 wing	-			,
	1		V V Z	1~marb		ture	7/4/ Se	wing	5/2	50	E XI	
	Sta Registi			2 2009	Julian a Gigila	id a	Someth B					

			, FOI	artment of Health and Mental I	Hygiene
			Trograma	ertificate of Death	Peath 3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Month	Day Year
•	/Medic Examin		OLIVIA WILKERSON  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	27,2006 7:05 A 4c. County of Death
	EXAMIN		JOHNS HOPKINS HOSPITAL	BALTIMORE	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/ If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month,	Birth Day, Year)  9. Birthplace (State or Foreign Country)
	Director		218 46 9575 1	MAY	5, 1949 MD.
	/land		10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits
	a-fsh	ctor	MD. N/A BA	LTIMORE	1 ☐ Yes 2 ☐ No X
	ith tha	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	rai	1005 WEBB COURT  11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Deceded at Historia Origin? (Specify Vac or	usa • No- 14. Race - American Indian,
	Item	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No	. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.	Black, White, etc.
99	hours after death with the Maryland turel', or Items 23a or 28a-f show at Even tinetr, ast be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give A Year or Dates:	1 ☐ Yes 2 ☐ No Specity:	Specify BLACK
215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "neturel", or Hems 23e or 28e-1 show event, The Miclical Exarchmetrals the notified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
	within 72 ene. than "nei	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) SERVICE WORKER	ARMARK
d 21	filed w Hygier Sther ti		8TH  17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	
au		To Be	JOHN EDMONDS	QUEENIE WI	LLIAMS
Maryland	s 1 and 2 should it Health and Men item 27 le marke other traumatic			ling Address (Street and Number or Rural Route Nu	
	1 and 2 Health tem 27 l		KIMBERLY EDMONDS /DAUGHTER 5	S KING HENRY CIRCLE	BALTO, MD. 21237
altimore,	Pages 1 ar		X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)	20c. Location - City or Town, State  BALTIMORE, MD.
<u>=</u>	permit. Pages Department of Importent: If i any Injury or one	1	`4 ☐ Donation 5 ☐ Other (Specify) TRINITY	CFM. MAR. 3, 20 22. Name and Address of Facility	006
Ba	permit. Departn Importe any Inju	l d		CALVIN B. SCRUGGS FU 1412 E. PRESTON ST.	JNERAL HOME BALTO.MDD 21213
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		
. 3	Pnysician:	8 11	· · · · · · · · · · · · · · · · · · ·	Mellites "	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):		
	Examiner	<u>.</u>	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):		
8	ted nsit	nine	cause. Enter Underlying		
,	execu n and ial-tra	Examiner	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):		
1760,	The law requires that the death certificate be executed at the attending physicien and tale has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	icai	d		
39 2	ertifica ling ph e as tl	Med	IF FEMALE:		
Вох	eath certific attending pl	Physician/M	in the past 12 mg/kms?	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
o.	uires that the de: signed by the a Id be detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	a cutof (specify)	
<b>a</b> .	s that ned b e deta	by Pf	Part II. Other significent conditions contributing to death but not resulting in the	undertying cause given in Part I. 23e. [	Did tobacco use contribute to the cause of death?
Records,	w require been sig should b			1	☐ Yes 2☐ No 3☐ Probably 4 ☐ Winknown
eco	e law re has be	Completed		a	Va.s an 24b. Were autopsy findings available prior to completion of cause of
= =		Corr		1 <b>-</b> Y	erformed? death? es 2 No 1 Yes 2 No
<u>S</u>	Physiclen: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check of Other: ACT Nursing Home 5 17 5	
Division of Vital	Phye	. To	27. Mann of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Descr	Residence 6 Other (Specify) ibe how injury occurred
0	Attending P r death. actor: After t by the funera	atior	1 atural 5 ☐ Pending (Month, Ďaý Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
<u>                                      </u>		Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f. Location City or	on (Street and Number or Rural Route Number, Town, State)
	Hospitel or Attended to the hours after death Funeral Director: tely filled in by the				
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one)  2□ Medical Examiner: On the basis of examination and/or and manner stated.		
	o the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)	->-0		April 1	D28266.	3/1/06.
	X		30. Name and address of person who completed cause of death (Item 23a) (Typ	a, Print)	
	* \		Aye Luini. ND. SDIO YORK Rd.,  31. Date filed (Month, Day, Year)  328 Registrar's Signature	Balto-mg. 21212_	
	Sta Registi		MAR 0 2 2006	selle	
		0	WILLIAM FOOD PROPERTY SA DES		

			For State Registrar	State of Ma	aryland				lealth a	and M	-	giene Reg. No.	006	5 (	6303
	Physici	an	1. Decedent's Name (First, Middle, La	•						p p	2. Date of De.	Day	Yes		. Time of Death
	/Media	al	Helen France: 4a. Facility Name (If not institution, giv				4h City	Town or	Location o		BRUAR'		ounty of D		0:50FM
	Examin	ier	Saint Joseph	Medical			If Under			0 W S O			Ba	ltin	
	Funeral Director		5. Social Security Number 6. S 215-82-7372	ex □ M 2X F 7		ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da April I	1, 19	35 M	Country)	(State or Foreign Land
	pu »		Usual Residence of Decedent  10a. State 10b. County		100 Cib	, Town or Lo	antian							104	Inside City Limits
	Maryla fetat	ğ	MD Baltime	ore		rkton									1 ☐ Yes 2 🛣No
•	permit. Pages ? and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow any injury or other traumatic event, Ite Medical Examinar must be notified at ance.	by Funeral Director	10e. Street and Number 818 Miller Ro	oad	-		10f. Zip	Code 112	0			-	en of What	: Country?	
	tema terminar	nner	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13. \	Was Dece	dent of Hi cify Cuba	ispanic Origin, Mexican	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	- 14	4. Race - A Black, W	mencan I /hite, etc.	ndian,
920	urs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 □ Yes 2 🖎 N If Yes, Give Year or Dates:	No		1 🗆 Yes	2 <b>X</b> No	Specify:			5	Specify: W	Vhit	е
21215-0036	72 ho 'natur	Completed	15. Decedent's En (Specify only highest gra	ducation de completed)		16a. Deced	dent's Usus kind of wo	al Occupa	ation during mosi	t of workir	ng	16b. Kin	d of Busine	ess/indust	ry
121	within ene. than '	ompi	Elementary/Secondary (0-12)	College (1-4or 5	5+)		emak		0			0	wn H	ome	
nd 2	al Hygi d other	Be Co	17. Father's Name (First, Middle, Last,								(First, Middle,				
yla	Ment Ment Markac	To Be	John Waltermy			401 14 10		/0:			Turnb			7. 0	4-1
Maryland	od 2 sh Ith and 27 Is n traun		19a. Informant's Name/Relationship ( JoDawn Amos/Da				-				rkton,			e, <i>zip c</i> o. 1 20	de)
e,	is and the all tem other		20a. Method of Disposition		20b. PI								ation - City	or Town,	State
<u>i</u>	Page ment c ant: If ury or		1 ☐ Burial 2 X Cremation 3 X `4 ☐ Donation 5 ☐ Other (Specif		Cre	lace of Dispo emetery, crer (Orkto ematic	owne on S	ervi	ce 2	006			c, PA		
Baltimore,	permit. Depart import any inj once.		21. Signature of Funeral Service Licer	Herno	ane						. Hart w Fre				ary,Inc.
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lir aRECURF Due to (or as	RENT	GLID						rrest,		Int	proximate erval Between aset and Death
	Examiner		Sequentially list conditions.	, VASO	SENI	EDE	MA								
V	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):									
0,	icate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last	CDue to (or as	a consequ	uence of):									
8760,	cate be physici the bu	dicai		d											
Box 6	law requires that the death certificate be executed es been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic p					23	3d. Date of Month	delivery Day	y Year
P.O.	at the c by the tachec	hysi	9 Unknown	9□ Unknown											
Records, F	w requires that been signed I should be det	ed by F	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	nderlying o	ause givi	en in Part I.		23e. Did t	1	/	e to the c Probably	ause of death? y 4 □Unknown
eco	faw requires been a 2 should	Completed									24a. Was autor	osv	prior	to comple	findings available etion of cause of
a B	n: The licete he										1 Yes	rmed? 2 X No	death 1 🔲 Y	Yes 2	No
Vital	Physiclan: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ■ No	Hospital: 1 npatie	 ent 2∏I	ER/Outpatier	nt 3 🗆 D0	Oth	00		(Check only only only only only only only only		□Other /5	Specify)	
n of	ng Phy Iter thi	n: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry	28b. Time of		28c. Injun Worl		_	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	Attending r death. sctor: After y the fune	icatio	2 Accident investigatio 3 Suicide 6 Could not b	e Ogo Place of Ini	umr. At ho	me form str	M		Yes 2□	_	28f. Location (	Street and	Number	r Bural Br	oute Number
Divi	after of Direct of in by	Certification;	4 ☐ Homicide determined	28e. Place of Injubulding, et	c. (Specify	me, rarm, str	eet, ractor	у, опісе		2	City or To		TABINDOI OI	ribiarri	oate ramper,
	To the Hospital or Attending Physician: The law Within 24 hours after death.  To the Funeral Director: After this certificate hes completely illed in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) Certifying Physics (Check only one)	nysician: To the best niner: On the basis of and manner sta	f examinat	wledge, deatl tion and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	nd place, a th occurre	and due to the ad at the time,	cause(s) a date and p	ind manner	r as stated	d. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	200	1	10 - 10	29	c. Licens	e number				signed (M	-	402
)			Joy Inder P	11171	hla	IN.C		D41	410			1-ehr	er orey	1.20	172006.
	5		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print)								
,	Sta	ate	JOGINDER P. MEI 31. Date filed (Month, Day, Year) MAR 0 2 200	32. Registr	ar's Sama	ture 0		DR	IVE	TOK	ISON, M	ARYL	AND_	2120	24
	Regist		MAR 0 2 200	O photogram	Section 1	8									

			For State Registrar	State of Marylar		artment of Hertificate of C			ene 006	06304
	Physicia		1. Decedent's Name (First, Middle, Las Wilma Azzi	st)				2. Date of Death Month	Day Year	3. Time of Death
5	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or I	Location of Death	Ua I	4c. County of Dea	ith
	ZXGIIIII	Ŭ.	rostburg Village	Nursing Care C	enter	Frost			Allega	ny
	Funeral		<ol><li>Social Security Number 6. S</li></ol>	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		rthplace (State or Foreign ountry)
Ь	Director		282-18-9154 Usual Residence of Decedent	□ <sup>M 2</sup> <b>X</b> □ <sup>F</sup> 85	Yrs.			9/20/19:	20	ОН
	land wo		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary -f sh	ţō	MD Allega	nΨ	Frostb	urg				1 X Yes 2 ☐ No
	r 28s	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show ledical Examinar must be notified at	aD	l Kaylor Circle			2153	32		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
9	s afte	by F.	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes XX No If Yes, Give	i	1 ☐ Yes 2 🛣 No			C	hite
2-003b	72 hours after natural', or ite		15. Decedent's Ec	Year or Dates:	163 Dece	dent's Usual Occupat	tion	16	b. Kind of Business	
Ċ	in 72 n "na hadic	Completed	(Specify only highest gra	de completed)	(Give	kind of work done du DO NOT use retired)	uring most of work	ing	o. Kind of Dusiness	unidustry
717	d within giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemaker			Own Ho	ome
and	be filed ital Hygir d other event, I	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)	
<u>a</u>	should b nd Mente marked umatice	10	Moses Elekes	Ann Debrie II			Katie	Rigo		
Mar	C1 42 = 20	0 3	19a. Informant's Name/Relationship (	,		ng Address (Street ar			-	
e, Z	l and lealth		Reynaldo Azzi, Jr 20a. Method of Disposition	./son		White Pin			c. Location - City o	
<u>כ</u>	f fite		1√2 Burial 2 ☐ Cremation 3 ☐	memovas nom State		osition (Name of matory or other place		2006		
	it. Pa		4 Donation 5 Other (Specify 21. Signatur 1 Funeral Service Licen			w Cemetery			Martins F	ne, P.A. for
ğ	permit. Pages Department of Important: If It any Injury or o		11/1/1/1/1	1 XVIMI	// He	slop Funeral	L Home, 415	Walnut St.	Martins 1	Ferry, OH 43935
			23a. Part I. Enter the disease, or com-	plications that caused the dea						Approximate
	Physician		spock or heart failure. List only Immediate Cause (Final disease or condition	PNEU MO	NIA				^	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		-				sont 3 day
	Examiner		Sequentially list conditions	h						
	p ii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consec	quence of):					
	be executed ician and burial-transit	Examln	that initiated events resulting in death) Last	c Due to (or as a consec	augus of):					
8/60,	cate be executed obysician and the burial-transit	alE		Due 10 (01 as a consec	quence on.					
180	death certificate e attending phys id for use as the	edical		_ d						
XOD	nding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		7-			23d. Date of de	elivery
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnancy Other (specify)			Month	Day Year
r Ö	at the by th	Physiclan/M	9 🗆 Unknown (	9⊡ Unknown						
Ś	w requires that the death certific been signed by the attending pl should be detached for use as i	ρ	Part If. Other significant conditions of				n in Part f.		_	o the cause of death?
ecords,	requi	ted	DEMENTIA CORONARY	1 1 TD 0. 0.				1 LI Yes	2 No 3 P	robably 4 Unknown
ê	a a c	Completed	Coronary	ANGERY DI	572AS)5			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
ᇙ	ate pa							1 ☐ Yes 2	ZNo 1 ☐ Ye	
VItal	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1   Impatient 2	ER/Outpatier	Other	26. Place of Death		a COtto (0)	
ō	Phys or this oral dii	<b>⊢</b> ⊦	27. Manner of Death	28a. Date of fnjury	28b. Time o			28d. Describe how	injury occurred	эспу)
0	nding ath. r: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? 'es 2 □ No			
UIVISION	ar deg	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location (Stree City or Town,		lural Route Number,
5	rs after or all billing in	Cer		Dunang, dia. (Open						
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Example 1	ysician: To the best of my knoniner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my opi	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	•		29c. License		29d	. Date signed (Mon	th, Day, Year)
)	٥		7	tolhn		1260	907	F	EBRUARY	10,2006
	3		30. Name and address of person who		,	,	7 1 -			
			Dr. Harjit S. S: 31. Date filed (Month, Day, Year)	idhu, 925 Bish 32. Regietrar's Sign		sn Road, (	Lumperlan	a, MD 215	OUZ	
	Sta Registr		FEB 1 0 2			Rosell .				
			,		Fred .	107 ACC 107 ACC				

				State of	f Marylan	•	rtment of I tificate of		and M	-	giene Reg.No.	6 (	1630	5
			Decedent's Name (First, Middle, Last,	)					-	2. Date of De	ath	<u>U</u>	3. Time of D	eath
	Physici		Evelyn V. Brumb	augh						Month Februa	ery 13,	Year 2006	3:00	a.m.
	/Medic Examin		4a. Facility Name (If not institution, give	street and nun	nber)			4b. City, To	wn, or Lo	cation of Deat	4c. County	of Death		
			Brooke Grove Nurs	ing Ho	me			Sandy	Spr	ing	Mont	gomer	-	
	Funeral		Social Security Number     6. Security Number		7. Age (In yrs.		If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthpl Count	ace (State or i	Foreign
	Director		232-28-0745	]M 24□ F	84	Yrs.				April 6		West	Virgin	iia
	and W		Usual Residence of Decedent  10a. State 10b. County		10c, City	y, Town or Loc	ation		_			10	d. Inside City	Limits
	Aaryli F sho	ō	Maryland Montgome	rv		ver Sp							1 ☐ Yes 2	_
	the 7	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of V	Vhat Count	ry?	
	a or		15201 Elkridge W	ay, #1	K		20906	5			USA			
	hours after death with the Maryland ural', or ttems 23a or 28a-f show I Examinat must be multied at	Funeral		12. Was Dece	dent Ever in U,	S. 13. V	Vas Decedent of	Hispanic Ori	gin? (Spe	ecify Yes or No		e - America		
<b>5</b>	after or Ite		1 Never Married 2 Married	Armed For 1 ☐ Yes	2 No		Yes, specify Cub  ☐ Yes 2☑ No		, Puerto	Hican, etc.)		k, White, 6 White		
713-0020	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da			L 105 ZIZINO	Specify.			Specify	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
ה	"natural", edical Ex	Completed	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>		16a. Deced (Give	ent's Usual Occu kind of work done OO NOT use retire	pation during mos	t of worki	ing	16b. Kind of Bu	usiness/Ind	ustry	
	filed within 72 Hygiene. ther than "nat	ш	Elementary/Secondary (0-12)	College (1	-4or 5+)		nistrati				Federa	1 Co.	0 74-0 TO 0	
7 7	iled v Hygie her t		17. Father's Name (First, Middle, Last)			Adill	HISCIACI				, Maiden Surnam		erumen	
yland	e de la la la la la la la la la la la la la	Be	Garrett Van Metr	e.						11myer	, maidon bannan	.0,		
_	should be nd Mentel marked umatic ev	7	19a. Informant's Name/Relationship (Ty			19h Mailin	n Addrass (Stree	1			er, City or Town,	State. Zip	Code)	
<u> </u>	C @ 8 8		Catherine B. Dunc		ghter						ederick			
ā,	of Health item 27 cother tr		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of natory or other pla	2001	-	Date	20c. Location -	City or To	vn, State	
pallimol	permit. Pages Department of I Important: If ite any Injury or or once.		1 ☐ Burial 2 ▼ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		State		n Cremator			eb. 14, 2006	Alexan	dria,	Virgi	nia
	artm ortar		21. Signature of Funeral Service Licens						Yns	Funeral	Home I			
ŏ	Deg drug		Ben: 28	ili		50	0 Univer	sity	Blvd	, W, S	lver Sp	ring,	MD 20	901
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that ca	aused the deati	h. Do not ente	er the mode of dy	ing, such as	cardiac o	or respiratory a	rrest,	1	Approximate Interval Between	
ξ.	Physician		Snock, or neart failure. List only of	ne cause on ea	ach line.							!	Onset and De	eath
	/Medical		Immediate Cause (Final disease or condition	RUSE	RATO	ا بنا	MILLU	ne				:	24 160	rens
	Examiner	L	resulting in death)	. 13 9.		r as a consequ						1		
	si ad	Examiner		CHAR	Nic in	TERST	ITIAL F	MILM	0.Wh	RY FI	BRUSIS		3 Yeth	125
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, 10,	icete be executed physician and s the burial-transit	alE	cause. Enter Underlying Cause (Disease or injury	o						-				
9	v requires that the death certificete be executed been signed by the attending physician and should be detached for use as the burial-transit	edical	that initiated events resulting in death) Last		Due to (o	r as a consequ	ience of):					1		
XOD	certif nding use a	Ž	•	d										
Ď	atter d for	cla	Part II. Other significant conditions cor	stributing to de	eath but not ree	ulting in the un	derlying cause g	iven in Part I		23h Did	tobacco use co	ntribute to	the cause of	death?
5	requires that the death certif seen signed by the attending hould be detached for use a	Physician/M	74.650 10 1.00 -24.0	-		-				1 🗆	Yes 2XNo	3 ☐ Prob	abiy 4⊡U	nknown
ζ. T	s that	by P	CONGESTIVE	1 felt	NT 17	+/L'UN2	6				7.			
ğ	auire en sig ould b									24a. Was	an autopsy	ava	re autopsy fin ilable prior to	_
ecoras,	law re les be s 2 sho	Completed											npletion of car leath?	use
_	sician: The law certificate hes b lirector, page 2 s	ĕ								10	Yes 2 No	1	Yes 2□ N	10
vital n	lan: artifica ctor,	Be	25. Was case referred to medical examiner?						of Deati	h (Check only	оле)			
	Physician: r this certific aral director,	ပ	1 ☐ Yes 2 No		npatient 2		3L DOA				dence 6 □Oth		)	
<u></u>	ing P	ü.	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of	h, Day Year)	28b. Time of Injury	28c. Inju	ork? ]Yes 2□		28d. Describe	how injury occur	rea		
3	tend death stor: /	Icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place	of Injury - At he	ome farm stre	eet, factory, office			28f. Location /	Street and Numb	er or Rura	Route Numb	·Θ <i>Γ</i> .
Division or	or Al efter Direc	Certification:	4 ☐ Homicide determined	buildir	ng, etc. (Specif	y)	ot, factory, office	•			wn, State)			,
	spital nours nerel / fillec		29a. Certifier 1 Certifying Physics	siclan: To the	best of my kno	wiedge, death	occurred at the t	ime, date an	d place,	and due to the	cause(s) and ma	anner as st	ated.	
	To the Hospital or Attending Physician: within 24 hours either deals the Tunerel Director: After this certific completely filled in by the funeral director, completely filled in by the funeral director,	edical	(Check only 2 Medical Exami one)	ner: On the ba and mann	asis of examina	tion and/or inv	estigation, in my	opinion, dea	th occurr	ed at the time,	date and place,	and due to	tne cause(s)	
	To the complete compl	Ň	29b. Signature and title of certifier					se number			29d. Date signe			6
	5		Am den								Februa			
			30. Name and address of person who co	ompleted cause	e of death (Iten	n 23a) (Type, I	Print)	00	מע	SILVI	en seni	14 1	un >	Uni
			Jimes A. Rossi,	MO =	3305 A	, Leisu	ne war	נט שו		1 31 64		,	7 20	106
	Sta Registr		31. Date filed (Month, Day, Year) FEB 15 20	06 32 R	egistrar's Signa	iture	est.							
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			1 - For State Registrar	State of Ma			tment of F ificate of		d Menta	I Hygier Reg.		16	06306
	Physici /Medic		1. Decedent's Name (First, Middle, La Lucile M.	st) Barnan	rđ				Mor	e of Death oth oruary	Day 13,	Year 2006	3. Time of Death 3:40 P M
1	Examin		4a. Facility Name (If not institution, giv				4b. City, Town, o				4c. Count		
	Funeral Director		9621 Lorain Avenus 5. Social Security Number 6. S 219-54-6241		92 Y		If Under 1 Year Months Days	Spring If Under 24 H Hours N	Hrs. 8. Date	of Birth oth, Day, Ye	ar)	Cou	place (State or Foreign intry) CONSIN
	ם .		Usual Residence of Decedent		10 0: 7								
	death with the Maryland ms 23a or 28a-f show froughte notified at	or	10a. State 10b. County		10c. City, Town								10d. Inside City Limits 1 ☐ Yes 2X No
	the N	Director	Maryland Montgo	omery	Silver	Sp	ring 10f. Zip Code			10g.	Citizen of	What Cou	
	th with		9621 Lorain Ave	enue			20901					USA	
2-0030	be filed within 72 hours after death with the Marylar at all typiene. die thypiene. die the than "natural", or items 23a or 28a-1 show arent, the Madical Examinational be notified at avent, the Madical Examinational be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 St If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba		? (Specify Ye uerto Rican, e	s or No- atc.)	Bla	ce - Amenick, White fyWhit	
ָבְּ ה	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation	16a. I	Deceder (Give kı	nt's Usual Occup	ation	working	16b	. Kind of E	Business/Ir	ndustry
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N	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last		Н	lome	Maker	18. Mother's I	Name /First.	Middle Maid		Home	
land	2 should be filed won and Mental Hygie file marked other traumatic svent, In	o Be	James H. Mair						lla Fi				
ary	shou and M mar	-	19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing	Address (Street	and Number or	r Rural Route	Number, Cit	ty or Town	, State, Zij	c Code)
Ma.	and 2		John R. Barnard/	Son			7 Clifto		, Silve	er Spr	ing,	MD	20904
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or obber traumatic syons.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				tion (Name of htory or other place ven Cemete:		Date oruary 1 2006	6,		,	own, State
Dall	permit. Departr Imports any inje		21. Signature of Funeral Service ocea	1500		Fra 500	Name and Addre ncis J. Univers	ss of Facility Collin ity Blv	s Fune	ral Ho	ome T	nc	, MD 20901
	Physician		23a. Part1. Enter the disease, or com shock, or flean failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	the death. Do no	ot enter	the mode of dyin						Approximate Interval Between Onset and Death 6 Years
	/Medical Examiner		Tosulary in South)		consequence o								Terre Monococci
	Hr. est	-e-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	Stenosi consequence of								24 Years
	outed nd ransit	Examiner	that initiated events	. General	ized At	hero	oscleros	is					25 Years
00/00	ificate be executed physician and as the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a	consequence of	f):							
O. BOX 0	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 decired at 1 ☐ Live birth 2 decired at 1 ☐ Live birth 2 ☐ Unknown	2 Fetal death		ctopic pregnancy Other (s <i>pecify</i> )					ate of deliv	ery Day Year
cords, r	tuires that n signed b	by P	Part II. Other significant conditions of Hypertension, Ren	_	•	the und	erlying cause giv	en in Part I.	236	a. Did tobaco	_		he cause of death?
neco L	The law red te has bee age 2 shor	Completed							-	a. Was an autopsy performed Yes 2		Were auto prior to co death? 1 \( \sum \text{Yes} \)	opsy findings available ompletion of cause of
	ian: artifice ctor. p	BeC	25. Was case referred to medical examiner?					26. Place of I			140	10163	20110
5	hysic his ce Il dire	ို	1 ☐ Yes 2 🖾 No		nt 2 ER/Out	patient		4   Nursin	gHome 5₺				(y)
DIVISION	ending P sath. or: After t he funera	atlon:	27. Manner of Death  1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		y 28b. Ti Year) In	me of jury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. De	scribe how in	пјигу осси	rred	
2	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death, To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificat	4 Homicide determined	building, etc	. (Specify)				City	or Town, St	tate)		al Route Number,
	he Kosp in 24 hou he Fune pletely fil	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best on niner: On the basis of and manner sta	examination and	death o	occurred at the tin stigation, in my o	ne, date and pl pinion, death o	ace, and due ccurred at the	to the cause time, date	e(s) and m and place,	anner as s and due t	stated. o the cause(s)
	To Com	Σ	29b. Signature and title of certifier	Donasi	la ole A	u	29c. Licens D12						Day, Year) , 2006
	1>		30. Name and address person who George F. Sengst	completed cause of detack, M.D.	ath (Item 23a) (1 3929 F	Type, Pr e <b>rr</b> a	int) ara Driv	e, Silv	ver Spr	ing,	MD 20	906	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 15 20	32 Registra	r's Signature	ban	(h)						

		-	For State Registrar		State o	f Marylan	•	artment of F		ind M	F	Reg. No.	06	06307	
ı	Physicia		Decedent's Name (First Helen		uise	C	rider				2. Date of Dea Month	Day	Year 23 2(	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not in				ilaci	4b. City, Town, o	r Location o	f Death	rebr		ounty of Deal		
			Sacred Hea		tal			Cumber If Under 1 Year		04 Hrs	O Date of Dist		egany		
n.	Funeral Director		<ol> <li>Social Security Number</li> <li>215-44-7713</li> </ol>	6. Sex	M 217 F	7. Age (In yrs. 62	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Day Jan 2,	1944	9. Bin	thplace <i>(State or Foreign</i> ountry) MD	)
	D.		Usual Residence of Deced				tv. Town or Lo	ootion						10d. Inside City Limits	
	Maryla f show	ō		Mineral		100. 0	Keyse							1 □ Yes 2 □ No	
	h the l	Funeral Director	10e. Street and Number	_				10f. Zip Code				10g. Citize	en of What Co	ountry?	_
	ath wit	ralD	Route 2 Box		- 144 -				26726			14	USA 1. Race - Ame	-day ladion	
	fter de ritems	Fune	<ul><li>11. Marital Status</li><li>1 □ Never Married 2</li></ul>		Armed Fo	edent Ever in U orces? 2 ☑ No	I .	Was Decedent of H f Yes, specify Cub		gin r (Spe i, Puerto f	Rican, etc.)		Black, Whit	te, etc.	
903	ours a	5	3 <b>X</b> Widowed 4 □ D		1 □Yes If Yes, Gir Year or D	ve ^ Pates:		1□Yes 2KINo	Specify:				Specify: wh		
Maryland 21215-0036	n 72 h	Completed	(Specify only	ecedent's Educ highest grade	completed)		16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most d)	t of workin	ng	16b. Kind	d of Business	/Industry	
212	d withi	Comp	Elementary/Secondary	[0-12]	College (	1-4or 5+)	Homer				- 1	Own	Home		
nd	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show any falury or other traumatic event, I'm Mindion Examities in ust be notified at once.	Be	17. Father's Name (First, 1		\\/hito						(First, Middle, Duise Le			Mhite.	
<u> </u>	should nd Men marke marke	ဥ	19a. Informant's Name/Re				19b. Mailir	ng Address (Street	1				Town, State,	Zip Code)	_
	and 2 sealth ar m 27 is	1	Lisa Alt			aughter	Rou	te 2 Box 1	123		Keyse	er	M	/V 26726	
Baltimore,	Pages 1 and the part of He part: If item ary or oth		20a. Method of Disposition		emoval from	State	cemetery, crei	nsition (Name of matory or other pla	1 1		ate 2/25/2006		ation - City or		
<u>=</u>	artmen artmen ortent: injury		'4 □ Donation 5 □ C		ю.	Res	4	emorial Gal				LaV	ale	MD	-
Ba	permit. Departr Importe any inj		Minhol	000 4	. Acc	21000	1-	Name and Address Scarpel 108 Viro			me, PA Cumber	land I	MD 2150	12	
			23a. Part1. Enter the dise shock, or heart failu	ase, or complice. List only on	e cause on	caused the dea each line.	th. Do not ent	er the mode of dyi	ng, such as	cardiac o	r respiratory ai	rest,	7	Approximate Interval Between Onset and Death	
	Pnysician /Medical	8 7	Immediate Cause (Final disease or condition resulting in death)	a		ute		cardio	1 /	rvtá	rction			Ihour	
B	Examiner				1	or as a consec	1 1	erosclen	25/5					5 years	
-	p #	ner	Sequentially liet condition if any, leading to immedia cause. Enter Underlying	te J		(or as a conse								-	
<b>V</b> _	and and il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.		(or as a consec	quence of):								
8760,	ate be executed hysician and the burial-transit	calE		۵											
9	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Medi	IF FEMALE:										1000-11-0		
Вох	leath certific attending p	Physician/Med	23b. Was decedent pregr in the past 12 month	iami	1 Live	tcome of pregn birth 2 Fet nant at time of	al death 3	☐Ectopic pregnanc☐Other (specify) _	'y			23	3d. Date of de Month	livery Day Year	
P. O.	t the di by the ached	hysic	1 ☐ Yes 20 No 9 ☐ Unknown		9□ Unkr						_				-
	res that the de signed by the a l be detached f	by	Part II. Other significant		tributing to d	1.	sulting in the u	nderlying cause gr	ven in Part I		23e. Did t			o the cause of death? robably 4 Dunknown	,
Records,	w requir been si should	Completed	Diabet	E) //	16 111	// >					24a. Was			utopsy findings available	
Rec	he lav e has age 2	dmo									autor		prior to death? 1 ☐ Yes	completion of cause of	
Vital	icien: Th certificate ector, pag	BeC	25. Was case referred to examiner?							of Death	(Check only o	-			_
of V	this at dir	은	1 ☐ Yes TNo  27. Manner of Death	Н			ER/Outpatie	nt 3 DOA	0.00		ne 5 🗌 Resid			ecify)	_
	fter mer	tion		Pending investigation	(Mor	of Injury oth, Day Year)	Injury	Wo	rk? ]Yes 2□		200. 200020	,,	00001700		
Division	r Attendi er death. rector: A	Certification;		Could not be determined		e of Injury - At I		reet, factory, office			28f. Location (. City or To	Street and vn, State)	Number or A	lural Route Number,	
	pital o		29a. Certifier	artifying Phys	rician: To th	a hest of my kn	nwladna daat	h occurred at the ti	ime date ar	nd place	and due to the	cause/s) a	and manner a	s stated	
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 N	ledical Examir	ner: On the I	pasis of examin	ation and/or in	ivestigation, in my	opinion, dea	ith occurr	ed at the time,	date and	place, and du	e to the cause(s)	
	To the To the Comp	Ä	29b. Signature and title o	certifier	) .	- ()	`		se number					th, Day, Year)	
			taul	1. Mu	4	we ald don't	) m 23a) /T		3774				ruary		
	2		Paul T. Li	person who co	& mD	se of death (Ite	Scton	Drive	Cum.	berl	and 1	Mary	land	21502	
0		ate	31. Date filed (Month, Da		32.	Registrar's Sign	nature	rell's							
	Regist	rair	MAR	0 2 200	b A	BURRA A	5 10						'		

		1 - State Registrer Cer	artment of Health and M rtificate of Death	Reg	ene() () 6	06308
Physici	an	Decedent's Name (First, Middle, Last)     E. Jane Chirdon		2. Date of Death Month	Day Year	3. Time of Death
/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		10 2006 4c. County of Death	10-10 A M
		Frostburg Village	Frostburg		Allegany	
Funeral Director		5. Social Security Number 194-09-1393  G. Sex 1 M 2 M F  7. Age (In yrs. last birthday) 90  Yrs.  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y NOV • 20,	(ear) 9. Birthy Coul. 1915 PENN	place (State or Foreign ntry) NSYLVANIA
Maryland 1-f show	tor	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 X No
n with the 3a or 28s	Funeral Director	10e. Street and Number 100 VILLAGE PARKWAY	10f. Zip Code 21532	10g	U.S.A.	ntry?
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23 a or 28a-f show other traumatic event, If a Medical Eventine traumatic event, If a Medical Eventine traumatic event,	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ XNO	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WH	
within 72 ho iene. 'than "natur i're Medical I	Completed	Elementary/Secondary (0-12)   College (1-4of 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired) AUTICIAN		Sb. Kind of Business/In	
should be filed and Mental Hyg marked other umatic evant,	To Be C	17. Father's Name (First, Middle, Last) WALTER PHILLIP WELLER		e (First, Middle, Ma ELIZABETH		
d 2 sho h and 7 Is m traum		1.12	ng Address (Street and Number or Run N. SMALLWOOD STRI			
os 1 and of Health itam 27 other tr		20a. Method of Disposition 20b. Place of Dispo		-	C. Location - City or To	
Pages ment of ant: if it		'4 □ Donation 5 □ Other (Specify) SS. PETER	& PAUL CEM. 02/14	4/2006	CUMBERLAN	ID, MD
perriit. Pages Department of I Important: if itt any injury or o		21. Signature of Funeral Service Vicensee  22.  23a. Part1. Enter the disease, or complications that caused the death. Do not en	2. Name and Address of Facility UPCHURCH FUNERAL 202 GREENE STREE	P, CUMBER	LAND, MD	21502 Approximate
Physician /Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	Hotery his	ical		Inierval Belween Onset and Death Years
sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Medical E	d	□Ectopic pregnancy □ Other (specify)		23d. Date ot deliv Month	ery Day Year
luires that n signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the u			cco use contribute to t	
The law rec ate has beer page 2 shou	Completed	Dementin		24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of 2 \( \subseteq \text{No} \)
To the Hostatel or Attending Physician: within 24, ours after death. To the Funeral Director: After this certifica completel, filled in by the funeral director, t	To Be	25. Was case reterred to medical examiner?  1	nt 3 DOA Other: 4 Nursing Ho	h (Check only one) me 5 Residence 28d. Describe how	ce 6 Other (Special	fy)
al or Atter s after dea al Director ad in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28t. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
ha Hostri in 24 rour ha Funerri pletely fills	edica	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occur	red at the time, date	e and place, and due t	o the cause(s)
To To to com	W	29b. Signature and title of certifier	29c. License number 271244		1. Date signed ( <i>Month</i> ,	
nos			Print)	1502		
	ate	31. Date filed (Month, Day, Year) 32 degistrar's Signature	P			

Mary A 06-103	inn Canz 60	zor.	etti Ple Unpend item#23a,i	ase Ty	pe or Pi erML C8	rint in E	Black In	delible	e Ink.	Ensu	re All	Copies	Are L	egible.	
AKG			For State Registrar		State of 1	Marylan				lealth a Death	nd M		Reg. No.	06	06309
	Physici		Decedent's Name (First, Min     MARY ANN		ZONET	ΓI						2. Date of De Month Febru	Day	Year 2006	3. Time of Death 6:05 P M
0	/Medic Examin		4a. Facility Name (If not institu 838 Gephart		et and numb	er)			Town, or ber1	Location of and	f Death	10010	4c. Co	ounty of Dea	ith
121	Funeral Director		5. Social Security Number 579–92–9408	6. Sex 1 ☐ M	2 <b>X</b> 1 F 7.	Age (In yrs. ) 45	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da DEC • 8	y, Year)		thplace (State or Foreign ountry) ARYLAND
	show	70	Usual Residence of Decedent  10a. State 10b. Coul	nty LEGANY	7		y, Town or Lo								10d. Inside City Limits 1
	n the N r 28a-f	Funeral Director	MD AL  10e. Street and Number					10f. Zip	Code				10g. Citize	n of What C	ountry?
	ath wil	ralD	838 GEPHART I						21502					S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nutified at once.	by Fune	11. Marital Status 1 ☐ Never Married 2 🛣 № 3 ☐ Widowed 4 ☐ Divord	larried	Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date	es? DXNo		Was Dece If Yes, spe 1 ☐ Yes		ispanic Orig in, Mexican, Specify:	jin? (Spe , Puerto I	cify Yes or No Rican, etc.)		Black, Whi	erican Indian, te, etc. HTTE
2-0	72 hou	eted	15. Dece (Specify only hig	lent's Educat			16a. Dece	kind of wo	rk done d	durina most	of workii	ng	16b. Kind	of Business	/Industry
2121	within iiene.	Completed	Elementary/Secondary (0-1	2)	College (1-4	or 5+)		DO NOT II RALEC		)			LA	W	
Maryland 21215-0036	uld be filec Mental Hyg irked oths	To Be C	17. Father's Name (First, Midd SERENUS WILL		OSSI						r's Name DYS	(First, Middle WENNI		umame)	
, Mary	and 2 sho saith and N n 27 is ma ar trauma		19a. Informant's Name/Relation CHRISTOPHER C			JSBAND		•	,		D, C	I Route Numb UMBERL	AND, I	MD 21	.502
Baltimore,	Pages 1 and the unit: if its mury or oth		20a. Method of Disposition 1 ☐ Burial 2 XCrematic 4 ☐ Donation 5 ☐ Other		noval from Sta	ate a	lace of Dispo emetery, crei BERLAN	natory`or o	other plac			l/2006			Town, State
Balti	permit. Departn imports sny inju		21. Signature of Funeral Serv	Licensee	exche	incl	22	UPCF 202	NO Address IURCH GREE	s of Facility FUNE ENE ST	RAL REET	HOME,	P.A. ERLAN	D, MD	21502
			23a. Part1. Enter the disease shock, or heart failure.	or complicat list only one	tions that cau cause on eac	sed the death h line.	n. Do not ent	er the mod	de of dyin	g, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	( a	Hyperte Due to (or	as a consequ		cular	Disea	se					
	sit sit	lner	Sequentially list conditions, any, sawing to inmovate cause. Enter Underlying Cause (Disease or injury	b	Oua to (or	as a consecu	uanna idfy								
,09,	icate be executed physiclen and s the burial-transit	al Examiner	that initiated events resulting in death) Last	c. <u> </u>	Due to (or	as a consequ	uence of):								
687	tificate be ng physicle as the bur	Medic	15 55111 5	d. =									- 1		
P.O. Box 68760	Attending Physician: The law requires that the death certificate be in death. If death. ector: After this certificete has been signed by the ettending physicle by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑️Unknown	23c.		n 2 ∏ Fetal tat time of de	Ideath 3	]Ectopic p ] Other (s)					230	d. Date of de Month	olivery Day Year
	es that thigged by be detact	by Ph	Part II. Other significant cond	litions contril	buting to deat	h but not resi	ulting in the u	nderlying (	cause give	en in Part I.		23e. Did 1	tobacco use	ontribute t	o the cause of death?
ords	v require been sig should b	ted b	Obesity; HIV; C	nronic H	lepatiti:	S						10	Yes 2□	No 3□P	robably 4 Unknown
Division of Vital Records,	ysician: The law is certificete has b director, page 2 st	Completed										1. Yes	psy ormed? 2 \( \text{No} \)	prior to death?	utopsy findings available completion of cause of
Vit.	sician: Th s certificete lirector, pag	To Be	25. Was case referred to med examiner?  1XX es 2 \sum No		pital:	atient 2	FR/Outnatier	nt 3□ De	Oth	0.00		ne 5 ☐ Resi		Kither (So	at scene
ion of	utending Physideath. ctor: After this y the funeral di	atlon; T	27. Manner of Death 1 XNatural 5 ☐ Per		28a. Date of		28b. Time o Injury		28c. Injun Worl		2	28d. Describe			sony)
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;		ed not be	28e. Place of building	Injury - At ho , etc. (Specif)		reet, factor	y, office		2	28f. Location ( City or To	Street and I wn, State)	Number or F	tural Route Number,
	e Hospih 124 hour 18 Funera Jetely fille	Medical (	29a. Certifier 1 Certi (Check only 2 Medicone)	ying Physic cal Examine	ian: To the be r: On the basi and manne	is of examina	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) ar date and p	nd manner a lace, and du	s stated. e to the cause(s)
		W	29b. Signature and title of cert	ifier				29		e number					th, Day, Year) 10, 2006
	711		30. Name and address of pers			of death (Item	n 23a) (Type,	Print)				timore			21201
	3 KD Sta	te		10, M		istrar's Signa		ı Per	шı St	reet,	LSQ	timore	, mary	y Lanu	212UL
2	Regist		31. Date filed (Month, Day, Xe FEB 1	ZUUb	AL.	باليا المسارة	1	Carlot of the Carlot							

			1 - For State Registrar	State of N	/larylan		artment of H				iene	16	06310
Serve	Physici	_	1. Decedent's Name (First, Middle, Marion L. Cur	Last) ran						2. Date of Deat Month Februar		Year 2006	3. Time of Death  11:55P M
1	/Medic Examin		4a. Facility Name (If not institution, 12413 Den1ey Ro		r)		4b. City, Town, or Silver S				4c. County	of Death	.1
	Funeral	2   1   2   1   2   1   2   1   2   1   2   1   2   1   2   1   2   1   2   2	5. Social Security Number 6		Age (In yrs. I		If Under 1 Year Months Days			8. Date of Birth (Month, Day, 9/26/19		9. Birth	place (State or Foreign ntry)
	Director		104-14-1590 Usual Residence of Decedent	ILIM ZEGE	82	Yrs.				9/26/19	23	Buff	alo, NY
	Marylan f ehow	or	10a. State 10b. County NY Erie		-	, Town or Lo awanda	ecation						10d. Inside City Limits 1 ☐ Yes 2 X No
	or 28a	Direc	10e. Street and Number				10f. Zip Code			11	Og. Citizen of	What Cou	ntry?
	death w	nerai	309 School Stre	12. Was Deceder Armed Force	nt Ever in U.	S. 13.	14217 Was Decedent of H If Yes, specify Cuba	lispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)		e - Ameri	can Indian,
036	urs after ai', or ite	by Fu	1 □ Néver Married 2 🛣 Marrie 3 □ Widowed 4 □ Divorced		No		**	Specify:			1	y: Whi	
215-0	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-1 ehow he Medigal Examinar must be mailied at	Completed by Funeral Director	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during mos d)	t of work	ing	16b. Kind of B	usiness/In	ndustry
d 21	filed wit Hygien ther th		12 17. Father's Name (First, Middle, La			home	maker	18. Mothe	er's Nam	e (First, Middle, M	own h		
ylan	Mental Mental arked o	To Be	Willard C. Kres	S						a Piske			
Mar	nd 2 shullth and 27 is m		19a. Informant's Name/Relationshi Barbara Reid-dau				ng Address <i>(Str</i> eet Lakeview						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23s or 28s-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			emetery, crei rest I	sition (Name of matory or other place awn Ceme	tery	2/18	/2006		o, Ne	ew York
Balti	permit. Deportra		21. Signature of Funeral Service Li	censee			Name and Addre						morial 1e,MD 20852
4	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each	line.	n. Do not en		ng, such as	cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	DISCIA	S/-					1 year
-	uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequ	uerice of).	0 ( )0-1 .						
8760,	cate be executed physician and the burial-transit	ical	that initiated events resulting in death) Last	d	as a consequ	uence of);							
P.O. Box 68	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of d	I death 3	Ectopic pregnancy Other (specify)	у				ate of delive	ery Day Year
	s that gned b	by	Part II. Other significant condition	SLC-C	_		nderlying cause giv	en in Part	l.		oacco use con es 2 □ No		the cause of death?
I Records,	The ate his page	Completed	RITEUMATIC	HEART	DIS	SEAS	i.e			24a. Was a autops perform	y qed?	Were autoprior to codeath?	opsy findings available ompletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ationt 2	ER/Outpatie	nt_3□ DOA Oth			h (Check only on		ner (Sneci	friend's
Division of Vital	ng After	tion; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of li (Month,		28b. Time of Injury	f 28c. Injur			28d. Describe ho			nouse
Divisi	i grad	Certification;	3 Suicide 6 Could no 4 Homicide determin	200. Place UI	Injury - At he etc. (Specif	ome, farm, st	reet, factory, office			28f. Location (St City or Town		ber or Rur	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical C		Physician: To the be xaminer: On the basis and manner	s of examina								
	6	Σ	29b. Signature and title of certifier	1			29c. Licens			2	9d. Date signe	ed (Month,	Dey, Year)
	6		30. Name and a dress of person w	no completed cause of	of death (Item						4141	106	
9	Sta	to.	ANDROW DUT	32 Regi	168 strar's Signa	iture 🏄	NNECTI	CUT	AUG	E, KEN	USING	TOR	, MD 2085;
	Regist		FEB 15	2006	الم معالما	J. Pop	ali						

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb 26, 2006 Year Dolly Sr. 11:38pm 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Allegany Cumberland Devlin Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 31, Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Deys 1 M 2 F Months Hours 1929 213-24-6089 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 Yes 2 □ No Allegany Cumberland 10f Zin Code 10g, Citizen of What Country? 10e. Street end Number USA 21502 135 N. Mechanic Street Apt. 504 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white **X** ☐ Widowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) seif-employed handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Belle Dolly Delmer Dolly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) MD 21502 165 National Hwy. LaVale granddaug Angel Colosimo 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 3/1/2006 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Na</sup> Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1₽Yes 2□ No 3 ☐ Probably 4 ☐ Unknown UR YULMON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy CY DISPASE 1 TYAS 2 ---1 ☐ Yes 2 2 No Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 □ Mố 28d. Describe how injury occurred 27 Manner of Death

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

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Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, the M-dical Exp. infort must be notified at

Baltimore, Maryland 21215-0020

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the M-dical Exc. when must be notilied at

Physician/Medical Examiner 2

Be

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Certification:

edicai

1 Natural

2 Accident

4 Homicide

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) MAR 0 2 2006

3 ☐ Suicide

29a. Certifier

8 page 2 should

law requires that the deeth certificate be executed attending physician and for use es the burial-transit ed by the a deteched f certificate has To the Hospital or Attending Physician: rector: After this certific by the funeral director, this death. filled in by within 24 hours e
To the Funerel C
completely filled

Division of Vital Records, P.O. Box 68760,

State Registrar

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 TYes

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

tiona

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year,

Chi who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar's Signature

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 9, Lucille Elizabeth Durrett 2006 7:05 P M February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 513 Welch Avenue Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕅 F Days Hours Yrs. Director 214-05-4467 10/12/1914 Vi<u>rginia</u> West Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ar than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No MD Cumberland Allegany Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 513 Welch Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Menfal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Harper Mary Mackenroth Homer Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 i Carolyn M. Myers / daughter 1018 Myrtle Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ita
eny injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 02/13/2006 Cumberland, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic breast cancer Physician year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death signed by the at Id be detached for 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by biabetes 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 No should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rma Leven D46346 February 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD 21502 31. Date filed (Month, Day, Year) FEB 1 0 2006 32. Registrar's Signature State 2014 Contract of the second

DHMH 17 Rev 1/2001

Registrar

			For Stata Registrar		Maryland	/ Depa		t of H	ealth a		lental Hy	_	6	06315
4	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle,  Janet Catheria  4a. Facility Name (If not institution,  Washington Co	ne Funkhou give street and num	ber)				Location o	of Death	2. Date of De. Month FEDRUAL	Day 4c. Count		- 11-1
2	Funeral Director		5. Social Security Number 131–24–5903		'. Age (In yrs. las	t birthday) Yrs.	If Under Months	-	If Under 2 Hours	24 Hrs. Min.	8. Date of Birl (Month, Da June 29	h y, Year)	9. Bir	thplace (State or Foreign ountry)  Wew York
	the Maryland 28a-f show otilized at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Wahs  10e. Street and Number	ington	10c. City, 1		miths							10d. fnside City Limits 1 ☐ Yes 2X No
	3a or	D	11801 Haven Hill	Drive			10f. Zip		783			10g. Citizen of	S.A.	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other traumatic event, Ite Modical Examinar must be notified at angle.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Narrie 3 Widowed 4 Divorced	Armed Ford	X No		Was Decedifies, special Yes, special	ent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto l	ocify Yes or No Rican, etc.)	- 14. Ra Bla		
21215-0036	within 72 ho ane. than "natur	mpleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4		(Give life. I	dent's Usua kind of won DO NOT us	k done d e retired,	luring most )			16b. Kind of E		
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ords, P	w requires that been signed b should be deta	ted by P	Part II. Other significant condition	s contributing to dea		ng in the ur	nderlying ca	use give	n in Part I.		23e. Did to	_/		o the cause of death?
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Divis	- 0	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place o building	f Injury - At home 7, etc. <i>(Specify)</i>						City or Tow	n, State)		ural Route Number,
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<i>(1)</i>	-7		30. Name and address of person w	no completed cayse	of death (Item 23	Ва) (Туре, І				2	10 01	HA	STRI	rain,
27	⊸ γ Sta	te.	31. Date filed (Month, Day, Year)	32. Bee	gistrar's Signature	) /	110/1	CNIC	AL (	AM	AUT RR	MA	21	742
	Registr	ar .	31. Date filed (Month, Day, Year)	2006	eur B.	Lys	cate							

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A.	3		Hegistrar     Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·			imeate o	Douth	2	Date of Death	g. No.		3. Time of Death
	Physici		Russell Nelson Fi	ceeman, S	r.				I	Month	Day 14 2	Year 2000	9:44 PM
	/Medio		4a. Facility Name (If not institution, give	street and number)			4b. City, Town	, or Location o		corolary	4c. County		
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	Funeral	-	Washington County 5. Social Security Number 6. Security Number 1.0	7. Ag		last birthday)	If Under 1 Ye Months Day		Min.	. Date of Birth (Month, Day,	Year)		ace (State or Foreign try)
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	/land		10a. State 10b. County		10c. City	y, Town or Lo						10	Od. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zip Code	9		10	g. Citizen of V	Vhat Coun	try?
	ath w	rail	61 Randolph Ave					21740			U.S		
	er de Itema	nne		12. Was Decedent Armed Forces?		S. 13. \	Was Decedent of Yes, specify C	of Hispanic Orig uban, Mexican	gin? (Speci n, Puerto Ric	fy Yes or No- can, etc.)	14. Raci Blac	e - Americ k, White,	an Indian, etc.
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Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-1 show or other traumatic event, the Madisal Examinar must be notified at	2	19a. Informant's Name/Relationship (Ty			19b. Mailin	a Address (Stre					State. Zio	Code) 21740
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ď	The law requires that the death certificat sie has been signed by the ettending phyage 2 should be detached for use as the	by Physician/Med	Part II. Dther significant conditions cor	tnbuting to death b	ut not resi	ulting in the ur	nderlying cause	given in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?
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of \	Physician: The la r this certificete has ral director, page 2	10	1 ☐ Yes 2 ☑ No  27. Manner of Death	lospital: 1 Inpatie		ER/Outpatien 28b. Time of	1 30 DOX			d. Describe ho			")
on	ding h. After funer	ţ	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	Year)	Injury	V	njuryat Vork? □Yes 2□I		a. Describe no	w injury occurr	90	
Division of	Attending Physician: r death. ector: After this certific by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At ho	me, farm, str						er or Rura	I Route Number,
Ö	s afte s afte el Dire	Certification:	4  Homicide determined	building, et	с. (Бресіт)	/)				City or Town	, State)		
	the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physical Check only 2 Medical Exemi	sicien: To the best	of my kno examina	wledge, death	occurred at the	time, date an	d place, and	d due to the ca	use(s) and ma	nner as si	ated.
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1	To o		29b. Signature and title of certifier	an. 1.	1	101	230. LIG	4/1/	7	28		(* _ /	1/
			30. Name and address of person o co	mnlated cause of d	eath (Item	23a) (Type	Print)	1700	/		2 . 1	1 . 0	6
1-	5-5		Michael T M	Cormela	/ /	11/0	Medica	1 Com	100	1/2:0	shu	, /	no.
100	Sta	ite	30. Name and address of person of community of the commun	32. Tegistr	ar's Signa	ture			Y		,		· L
	Registr	ar	FEB 16 200	O Bellen	- 1	. Spok	rest !						

			1 - For State Registrar	State of M	arylar	nd / Dep	artmer		ealth a		ental Hyg		1000	06	317
ı	Physic	ian	Decedent's Name (First, Middle, Last	st)							2. Date of Dea Month	ath Da	y Year		ime of Death
P	/Medi	cal	Lester R. Franke								ebruar	y 1	L, 2006	12	:05 P.M
1	Exami	ner	4a. Facility Name (If not institution, give						Location of	Death			County of Dea		
	* Funcial		Summerville Assi 5. Social Security Number 6. S			last birthday)		otoma	C If Under 2	4 Hrs.	8 Date of Birtl		1ontgom		Nata as Familia
	Funeral Director		,	<b>™</b> 2□ F	92	Ven	Months		Hours	Min.	8. Date of Birtl (Month, Day Dec. 22	, Year, 2 ,	1913 Nev	ountry) W Yor	Riate or Foreign
	rylan		10a. State 10b. County			y, Town or Lo	cation								ide City Limits
	e Ma	cto	Maryland Montgom	ery	Po	tomac								ıX,	Yes 2□No
	vith th	Director	10e. Street and Number				10f. Zi	p Code				10g. Ci	tizen of What C	ountry?	
	e 23g	ra	8720 Harness Trai					0854					S. A.		
	ter de ttem	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 17 Yes 2	1		Was Dece If Yes, spe	dent of His orfy Cuban	panic Origi , Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - Am Black, Wh		an,
336	urs af	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	™ Nav WW	T_	1 🗌 Yes	2 <b>X</b> ] No	Specify:				Specify: Wh	nite	
0-0	a within 72 hours after death with the Maryland Jione. I then "netural", or teme 23a or 28a-f show Tra Medical Exactinat transite rotified at	ted	15. Decedent's Ed	lucation	VV VV	16a. Dece	dent's Usu	al Occupa	tion			16b. K	and of Business	:/Industry	
215	within 7 ene. then "r	npie	(Specify only highest gra	College (1-4or	5+)	(Give life.	kind of wo DO NOT u	ork done du ise retired)	uring most o	of working	7			,	
7	filed wi Hygien other th	Completed		5+		Stat	isti	cian_				Mar	ket Res	searcl	h
and	0 7 5	Be	17. Father's Name (First, Middle, Last)								First, Middle,		Sumame)		
Z S	d Mer narke	J.	Jacob Frankel								oblowsk	,			
Maryland 21215-0036	irmit. Pages 1 and 2 should be spartment of Health and Menis portant: if item 27 is marked by injurymenther traumatic size.	1	19a. Informant's Name/Relationship (7)  Judith M. Novenst	•	rhtor								or Town, State,		
	1 an Heali		20a. Method of Disposition	erii - Dauş			-111			, I O	-	_	ocation - City or		ate.
õ	ages int of		1 Burial 2 Cremation 3 ☐ 4 Donation 5 ☐ Other (Specify		i	lace of Dispo									
Baltimore,	permit. Pag Department important: i eny inject		21. Signature of Funeral Service Licen		Jud	ean Me				/13/:			ey, Mar		1
ä	permit. Departrimporti		1 Tomald	Statel	mu	Ed.	ward	Sage	1 Fun	eral	Direct	ijor	i, Inc.	land	20852
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause, (Disease or injury)		oro V a consequ	ascula				ardiac or i	respiratory arr	est,		Onset	ximate al Between and Death Days
68760,	The law requires that the death certificate be executed tite has been signed by the attending physicien and bage 2 should be detached for use as the burial transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as d.	a consequ	Jence of):									
P.O. Box (	that the death certificated by the attending placed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pr						23d. Date of de Month	fivery Day	Year
	w requires that been signed t should be det	þ	Part ff. Other significant conditions co	ontributing to death b	ut not resu	ulting in the ur	nderlying o	ause given	in Part I.		23e. Did tot	7.7	use contribute to		of death?
Division of Vital Records,	ysician: The law re is certificate has be director, page 2 sh	Completed								_	24a. Was a autops perform	y	prior to death?	utopsy find completion	ings available of cause of
/ita	ifcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?								Check only on	е/			
5		은	1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatie		ER/Outpatien		Other	X Nursi	ing Home	5 🗌 Reside	ence	6 □Other (Spe	city)	
Ë	ding F	Ö	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year)	28b. Time of Injury		8c. fnjury a Work?	ıt	280	d. Describe ho	ow infur	y occurred		
<u>s</u>	ttend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	00 54 (1)	411		М		s 2 No	-					
<u>N</u>	To the Hospital or Attending Physicial Attending Physicial At hours after death.  To the Funeral Director: After the completely filled in by the funeral	Certification:	4 Homicide determined	28e. Place of Injude	c. (Specify	")					City or Town	n, State			Number,
	Hos 24 ho Fune Hely fi	edicai	29a. Certifier 1 Certifying Phy (Chack only one)	rsician: To the best of iner: On the basis of applicanner sta	of my know examinat	wledge, death ion and/or inv	occurred estigation.	at the time , in my opir	, date and p	place, and occurred	d due to the ca at the time, da	ause(s) ate and	and manner as	stated.	isə(s)
	o the o the o the	Med	29b. Signature and title of ceaffier	apo manner sta	1100			License r					e signed (Mont		
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ı	10	T	30. Name and address of person who co	ompleted cause of d	ex ,	2321/71:00	Print'	ספטע	J <del>4</del>		F €	PULU	ary 13,	, 2000	, 
			Barry RosenbAU					venue	, Ken	sing	ton, Ma	ary1	and 20	895	
- 6	Sta	te	31. Date filed (Month, Day, Year) FEB 15 2		ır's Signat		enti								
His o	Registr	ar	FEB 15 2	006	39.0 1	J. A.									

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Day Year S. HICE Goeser 2006 2 4b. City, Town, or Locetion of Death 4c. County of Death 4a Eacility Name (If not institution, give street and number) Allegany unexilere mo Manor If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1□ M 2□ F Yrs. 262-12-6375 87 Sep 29, 1918 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1002 Dent Lane 21502 USA 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: 3√ Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Rov L. Martin Blessing Bartholomew Strong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dan Goeser 1002 Dent Lane Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/25/2006 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home, P.A. Cresaptown MD 22. Nama and Address of Facility 21. Signatura of Funeral Service Licensee Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Prohably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2DNO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 → Nursing Home 5 → Residence 6 → Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 <del>⊟Na</del>tural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

pate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Funerai

δ

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than '

or other

**Physician** 

Medical **Examiner** 

Physician/Medical Examiner

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Completed

Be

Certification:

Medicai

or Attending Physician: after death.

Director: Aft
d in by the fur To the Hospital or Atter within 24 hours after der To the Funeral Directo completely filled in by th

Registrar

31. Date filed (Month, Day, Year) State

4 Homicide

29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0017565

Livile

MI

29d. Date signed (Month, Day, Year)

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJBOllino

922 N2+1

32. Registrar's Signature

			For State Registrar		State o	of Maryla			nt of He te of D		Mental H	ygiene Reg. No.	006	06319
	Physicia	ın	1. Decedent's Name		,						2. Date of D Month	Day	Year	3. Time of Death
	/Medic	al	ruth k					4h Cih	Taura and	and a of D	FEBRI		4, 200	
	Examin	er			RIAL HOM	,			ONSBO	ocation of Dea RO	atn		County of Deat ASHING	
F	uneral		5. Social Security N		6. Sex	-	s. last birthday	) If Unde	r 1 Year	lf Under 24 Hr	s. 8. Date of B	irth	9. Birt	thplace (State or Foreign
	rector		234-01-6		1 □ M 2 <b>XOX</b> F	90	Yrs.	Months	Days	Hours Min	10-16-	1915	WES.	T VIRGINIA
and	* -		Usual Residence of 10a. State	10b. County		10c. (	City, Town or L	ocation		***				10d. Inside City Limits
Maryi	f sho	ō	WV	BERKE	T.EY		MARTIN		·					1 □ Yes 2 No
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aftar e	el', or flems 23e or 28a-f sho Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Marr		Armed Fed 1 Tyes If Yes, G	No		1 ☐ Yes		Specify:	erto Hican, etc.)		Black, White Specify:	e, etc. WHITE
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an de be	kad o	To Be	SHANNO		MICHAEL	_				CARR		CIS G		
aryland	item 27 is markad other than "netu othar traumatic svent, It e Madical	-	19a. Informant's Na				19b. Mai	ling Addres	s (Street an		Rural Route Num			Zip Code)
and 2	Important: If item 27 Is any injury or othar tra 2005		MICHAE	L GRIM	M/SON		291	9 KOC	NTZTO	WN ROA	D FALLI	NG WA	TERS, V	WV 25419
S S S	f iten r oth		20a. Method of Dis		3 □Removal from		Place of Disp cemetery, cre	osition (Na ematory or	me of other place)		Date	20c. Loca	ation - City or	Town, State
Pag Pag	ant: I		` 4 □ Donation				ROSEDAI	E CEM	ETERY	2/:	28/2006	MAR	TINSBUI	RG, WV
Baltimore	Import any inj once		21. Signature of Fu	ineral Service L	icensee		1		nd Address	NATION AND ADDRESS OF THE PARTY.	ROSEDALE	ASSESSMENT OF THE	STATES ALTERED	TARROTATION
9	= e 0		23a. Arti. Enter t	-ha	complications that		-Ab Daniel	_			OAD MART		RG, WV	Approximate
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<b>58760, c</b>	physicia the bur	dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	5	с	o (or as a conse								
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rds	an sig	ed b	organ	sie lu	con n	yndro	re				1 🗆	Yes 2/2	No 3□Pr	obably 4 DUnknown
aw re	s been si 2 should	Completed	1		0	/					24a. Wa	s an	24b. Were au	topsy findings available completion of cause of
<b>R</b> 8	ate ha	E O									per	ormed?	death?	2 No
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of \	this c	2	1 Yes 2 2				ER/Outpatie			4 Nursing	Home 5 Res			cify)
Sing F	After	lon	1 Z Natural	5 Pending investig		nth, Day Year)	28b. Time Injury	M	28c. Injury a Work?	s 2 🗆 No	28d. Describe	now injury	occurred	
Division of Vital Records, or Attending Physicien: The law requires the after death.	To tha Funeral Director: After this completely filled in by the funeral di	Certification:		6 Could n determine	ot be 28e. Place	ce of Injury - At ding, etc. (Spec	home, farm, s cify)			3 2 110	28f. Location City or To	(Street and awn, State)	Number or Ru	ural Route Number,
Hospite	a Funeral etely filled	Medical C	29a, Certifier (Check only one)	1 Certifying	g Physician: To the Examiner: On the and ma	ne best of my ki basis of examil nner stated.	nowledge, dea nation and/or i	th occurred nvestigation	at the time n, in my opir	, date and plac lion, death occ	ce, and due to the curred at the time	cause(s) a	nd manner as place, and due	stated. to the cause(s)
. To th	To th	Me	29b. Signature and	title of certifier	1.1	1		29	c. License r	number		29d. Date	signed (Monti	h, Day, Year)
					Mym			-17	325	18		2/	25/06	
	3		30. Name and addr	BERT GL	JEDENET.	21 WYAN	ND DRIV	, Print)			MD 2175	6/301-	-432-22	222
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			State of Maryland / Departme			•	ziono	,
			1. State			, ,	000	6 06920
		-0,4	Registrer  1. Decedent's Name (First, Middle, Last)	ale or		2. Date of Dea	Reg. No.	3. Time of Death
	Physic	an				Month	Day	606 2:50 A M
	/Medi		James William Gorham  4a. Facility Name (If not institution, give street and number)  4b. Ci	ity, Town, o	or Location of Death	00100	4c. County	
	Examir	ıer	Doctor's Community Hospital Lan				,	e Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unit	der 1 Year	If Under 24 Hrs. 8	Date of Birtl (Month, Da)		Birthplace (State or Foreign Country)
	Director		228-54-4490 1\Q M 2□ F 63 Yrs. Month	hs Days		12/26/	1942	Virginia
	P .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	laryla • hov	5						1 Tes 2 No
2	the N 28a-f	Director	Maryland Prince Georges Lanham  10e. Street and Number 10t.	Zip Code			10g. Citizen of W	/hat Country?
4	with Sa or	ā		706			USA	
I	Jeath Tre 23	era	0,000		dispanic Origin? (Speci an, Mexican, Puerto Ri			- American Indian,
Q'	atter of	큔	1 □ Never Married 2 📉 Married 1 □ Yes 2 🔯 No	specify Cuba s 2⊠ No		can, etc.)		c, White, etc.
0	21215-0036 of within 72 hours after death with the Maryland glene. et than "naturat", or fleme 23s or 28s-1 show in the Madical Examinational be notified at	Be Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	s 2101 NO	<i>Specify:</i>		Specify.	White
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	Hygied N.	ပ္သ	12 Pressman  17. Father's Name (First, Middle, Last)		18. Mother's Name (	First, Middle,		
	d be antat	To Be	Marshall C. Gorham		Kattie Lo		_	•
3	Maryland d 2 should be file th and Mental Hy 17 1e merked oth traumetic event	F		ess (Street	and Number or Rural I			State, Zip Code)
			Frances Gorham/ Wife 6936 He	ide1b	urg Road L	anham,	MD 2070	16
18	othe othe		20h Mathad of Disposition //	Name of	Dat			City or Town, State
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	Baltimore, permit. Pages 1 at Department of Hea Important: If item eny injury or otha		21. Signature of Funeral Service Licensee 22. Name	and Addre	ess of Facility Robe	rt E.	Evans Fu	neral Home
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•	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the meshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Pneumocystis Carinii  Due to (or as a consequence of):  Glioblastoma Multiform	Pneum		respiratory an	rest,	Approximate Interval Between Onset and Death
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1	that bed by deta	y P	Part II. Other significant conditions contributing to death but not resulting in the underlyin	ng cause giv	ven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
	rds quire n sign					1 🗆 Y	es 2□No	3 ☐ Probably 4 🏚 Unknown
	S been si	Completed				24a. Was a	an 24b. W	/ere autopsy findings available
1	The law	E				autop perfor 1 Yes	med? d	rior to completion of cause of eath?
	VITAL P iclan: Th certiticate ector, pag	BeC	25. Was case referred to medical		26. Place of Death			
į	nysic hysic nis ce	P	examiner?  1 Yes 2XNo  Hospital: 1XInpatient 2 ER/Outpatient 3	DOA Oth	ner: 4 ☐ Nursing Home	5 ☐ Resid	lence 6 Othe	r (Specify)
	On Of VIta Iding Physiclan: Ih. After this certific funeral director,	tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation Manner of Death  28a. Date of Injury (Month, Day Year)  Injury	28c. Injur Wor 1 🗆	y at 28 rk? Yes 2 □ No	d. Describe h	ow injury occurre	bd
	DIVISION Of VITAI HECONDS, P.O. To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: Affer this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ctory, office	28	f. Location (S City or Tow		r or Rural Route Number,
	Hospite 24 hours Funeral tely fille	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurr of the basis of examination and/or investigation and manner stated.	red at the tir	me, date and place, an opinion, death occurred	d due to the o	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	o the ithin 2 o the	Med	29h. Signature and title of certifier	29c. Licens	se number	1	29d. Date signed	(Month, Day, Year)
	F 3 F 8		Dhalak Berzingi, MP	00	056901	3 3	2112/01	3
			30. Name and address of person who completed cause of death (Item 33a) (Type, Print)	100	,000/00	,	, ,,,,,,	
			YR. Chalak Berzingi 7500 Honover	Parki	vay Suite	15, Gr	cenbelt	MD 20770
	Sta	ate	31. Date filed (Month, Day, Year)  32. Begistrar's Signature	M .				

			1- For State of Maryland / Dep	partment of Health and I pertificate of Death	Mental Hygie Reg.	21116	06321
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Joseph Edward Geatz, Jr.		FEB.	1, 2006	4:09 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Mercy Medical Center	Baltimore		NIA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
	Director		215–56–8529 <sup>1</sup> XM <sup>2</sup> F 57 Yrs.		JAN. 27, 1		RYLAND
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	eho eho	៦	MD N/4 BALTIM				1 Dores 2 □ No
	the N	Director	10e. Street and Number	10f. Zip Code	10a	Citizen of What Cou	untry?
	with	ă	726 LIGHT STREET	21230		U.S.A.	
	be filed within 72 hours after death with the Maryland tal Hyglene. id other than "netural", or items 23e or 28e-f ehow event, the Madiral Exeminar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer	
_	fer d	표	1 ☐ Never Married 2 ☐ Married	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White	, etc.
2	or', o	þ	3 ☐ Widowed 4 🏋 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:		Specify: WH	TE
בָּ	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of wor	16I	b. Kind of Business/I	ndustry
Š	thin 7	J Ple	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)	9		_
Maryland 21215-0036	filed wil Hygien other th	Son		EACHER		EDUCATION	N .
	be filed tal Hygi d other event, i	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai		
<u>X</u>	should ind Meni	မ	JOSEPH EDWARD GEATZ, SR.		IA MCINTOS		
ā	C1 00 = 00		112	iling Address (Street and Number or Ru			ip Code)
2	日本に		District Theorem 1	804 RIDGE ROAD, MI		D 21771 c. Location - City or 1	Town State
9	Pages 1 all nent of Heal int: If item		A Novice Competion 2 Democratica State competery, co	position (Name of rematory or other place)			
altimore,	ment tant:			MEML.GARDENS 02/0		LAVALE, I	עשי
Rall	permit. Pages Depertment of Important: If it any injury or once.		21. Signature of Funeral Service Licentee	22. Name and Address of Facility UPCHURCH FUNERAL 202 GREENE STREE			21502
			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition 4 HEPATIC Fi	ALLURE		and the state of t	Onset and Death  DAYS
·	/Medical		resulting in death)  Due to (or as a consequence of):	_			<i>Di</i> 11-2
	Examiner		Sequentially list conditions   GASTROINTES	TINAL BLEE	DING		DAYS
_	п =	ner	if any, leading to immediate Due to (or as a consequence of):		,		
	ocute ind trans	Examiner	that initiated events c.				
Š,	e exe		resulting in death) Last  Due to (or as a consequence of):			3	
8/60	Attending Physician: The law requires that the death certificate be executed in death.  sector: After this certificete has been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit.	dical	d				
و	death certific attending pl	Med	IF FEMALE:				
ROX	ath ce	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death	B □ Ectopic pregnancy		23d. Date of deli	very Day Year
-	e de the a	Sic	1  Yes 2  No	5 Other (specify)			•
д О	that the de ned by the a detached f	듄	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tohar	co use contribute to	the cause of death?
Division of Vital Records,	res tha signed be del	by	Patell. Other significant contains contributing to death but not resulting in the	underlying cause given in Fair t.		2 □No 3 □ Pro	
5	w requir been si should	eted					
မ	e law has b	nple			24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
	The page	Completed			performe 1 Tes	death? No 1 ☐ Yes	2 🗆 No
<u> </u>	cian: ertific ector,	Be	25. Was case referred to medicat examiner?		ath (Check only one)		
	hysi his c	၉	1 ☐ Yes 1 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		lome 5 Residend		ufy)
چ	Ing P	on	27. Mannay of Death  ZNatural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Time Injury	y Work?	28d. Describe how	injury occurred	
<u>s</u>	tendi leath tor: A the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be	M 1 Tes 2 No	204 1 (51		10
$\leq$	I or At after d Direct I in by	를	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S	et and Number or Ru State)	rai Houte Number,
	ospital o hours at uneral D iy filled i	Ce	000 000000		and due 1- 15-		
	I 4 II 0	edicai	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number		. Date signed (Monti	, Day, Year)
	90		KRAholakia, MD	7006332	.6 F	EB 1	04
3:	: 3H		30. Name and address of person who completed cause of death (Item 23a) (Type				
	mu		KUSH. R. DHOLAKIA MD. ME	FRCY MEDICAL CO	ENTER !	SALTIMO	ee, MD 2/20
1.	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist	rar	FFB 0 6 2006   Beneral 18	(Section)			

		-	For State Registrar	State of Ma	aryland / Depa	artment of H			giene leg. No. 0 0	6 06322
			Decedent's Name (First, Middle, Last)	)				2. Date of Dea	ith	3. Time of Death
н	Physicia /Medic		Jack Thurman GREE	N				Month Feb.	Day 14 2006	Year 700 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	ath	4c. County of	
			545 Maryland Aven			Hagers	town		Wasl	nington 9. Birthace (State or Foreign
	Funeral		5. Social Security Number 6. Se	x 7.Age ZM 2□F	e (In yrs. last birthday) 70 Yrs.	If Under TYear Months Days	If Under 24 Hi Hours Min	1. (Month, Day	, 1001)	Birthplace (State or Foreign Country)
	Director	-	220-18-1530 Usual Residence of Decedent	•	78 Yrs.			April 2	4 1927	Maryland
	/land		10a. State 10b. County		10c. City, Town or Li	ocation				10d. Inside City Limits
	Many I-f sh	to	Maryland Washing	ton	Hage	rstown				11 Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	238 c	ai	545 Maryland Aven	ue		21	740		USA_	
	r dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
36	or It	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 ☐ N If Yes, Give		1 ☐ Yes 2¶ No	Specify:		Specify:	TT1- 4 4 -
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f show the Medical Eracili or hand be redified at	ed b	15. Decedent's Edu		WW II	dent's Usual Occup	ation		16b. Kind of Bus	White iness/Industry
5	n "na	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most of w	rorking		,
212	e filed within al Hygiene. other then " vent, Italie	E o	Elementary/Secondary (0-12)	College (1-4or 5	1	les Manag	er		Dair	·v
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "natural", or Itams 23a or 28a-f show event, the Medical Exaction or matter cutified at	Bec	17. Father's Name (First, Middle, Last)	•				ame (First, Middle,	Maiden Surname	)
<u>Ja</u> l	2 should be and Mental Is marked ( aumatic ev	2	Lewis Green				E11a	Dagenhart		
Maryland	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street	and Number or i	Pural Route Numbe	r, City or Town, S	tate, Zip Code)
	and sealth m 27	-	Lois I. Green - W	ife	545 20b. Place of Disp	Maryland	Avenue,	Hagersto	wn, Mary	1and 21740 ity or Town, State
Baltimore,	ges 1 all of Head		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ F		cemetery, cre	matory or other place	ce)	Date	200. Location - 0	ity of Town, State
Ë	trnen trnen tent:		*4 □Donation 5 □ Other (Specify,		Rose Hil	1 Cemeter	y2/1	8/05 -	Hagersto	wn, Maryland
Bal	permit. Pages. Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Licens	/ /		2. Name and Addre	_	Minnich		
			23a. Part1. Enter the disease, or comp	lications that caused		415 E. Wilter the mode of dying				Approximate
B	Pnysician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lii	ne.				^	Interval Between Onset and Death
			disease or condition resulting in death)	a / +/\dagger Due to (or as	a consequence of):	-otic (	araiv	L'ascul	ar 415	and Juyering
U					a concequentes on,					
		Je.	Sequentially list conditions, if any, leading to infinementate cause. Enter Underlying							
	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
ó	e exerian ar		resulting in death) Last	Due to (or as	a consequence of):					
8760,	e ys	lical		d		<del></del>				
9 X	entifica ding ph	Med	IF FEMALE:	23c. If yes, outcome	of prognancy				004 P-4-	of delicens
Вох	eath certific attending p I for use as	Physician/Med	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	/		Mont	of delivery th Day Year
0	at the de by the a tached	ysic	1 Yes 2 No 9 Unknown	9☐ Unknown	time of death 50	_ Other (specify)				
<u>a</u> .	The law requires that the death certifica ite has been signed by the attending phoage 2 should be detached for use as the		Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
Records,	luires than signed I	d by	Q. Diabetes	melli1	us-II	2) Hype	critens	101 101	′es 2)⊄No 3	3 ☐ Probably 4 ☐Unknown
CO	aw requir ts been si 2 should	Completed	(3) Klypp- 1	pidemio		7		24a. Was		ere autopsy findings available
Re	The lay ate has page 2	mo	9,00					- autop perfo 1 ☐ Yes	rmed2 de	rior to completion of cause of eath? □ Yes 2□ No
Vital		0	25. Was case referred to medical				26. Place of D	eath (Check only o		
f V	ys dis	To B	examiner? 1 \( \text{Yes} \) 2\( \text{No} \)	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3□ DOA Oth	er: 4 🗆 Nursing	Home Resid	ience 6 🗆 Other	r (Specify)
n of	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time (	Wor		28d. Describe h	now injury occurre	d
Division	Attending r death. sctor: After by the fune	catio	2 Accident investigation				Yes 2 □ No		3	Out Out Name
Ξ	l or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, si c. (Specify)	reet, factory, office		City or Tov		r or Rural Route Number,
	Hospitel 24 hours a Funerel I tely filled		29a, Certifier 1 Certifying Phy	reician: To the hest	of my knowledge, dea	th occurred at the tir	me date and pla	ce, and due to the	rause(s) and man	ner as stated
	To the Hospitel or a within 24 hours after To the Funerel Dire completely filled in b	edical	(Check only 2 Medical Exam	iner: On the basis o	f examination and/or in	nvestigation, in my o	pinion, death of	curred at the time,	date and place, ar	nd due to the cause(s)
	To the within 2 To the complet	₩	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
			1 / horac 14	www	TIPh.D.A	ID DI	7591		Feb. 1	6,2006
			30. Name and address of person who d	ompleted cause of c	leath (Item 23a) (Type	Print) ()		1.	1	1
/						2 1 1 1	- 17-	I Callad		1 ) 17/11
PS	57+1		11160 medica	e Can	pers Rd		e 130 i	Hagust	on M	21742
PS	∑ 7+/ Sta Registr		11(10 Medica 31. Date filed (Month, Day, Year) FEB 1772	2 Carre	pus Ra ar's Signature	Suite Joane	e 130 i	Magus	on M	21742

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of Hortificate of L		and M		iene 2006	06323	
			1. Decedent's Name (First, Middle, La	nst)					2. Date of Death		3. Time of Death	
	Physici /Medic		Kylee Ge	bhardt				FE	BRUARY	Pay, eva	6 4:40 M	
	Examin		4a. Facility Name (If not institution, gir Saint Joseph	Medical	Center	4b. City, Town, or		of Death OWS O	n	4c. County of De	ath timore	
	Funeral Director			Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours 3	Min.	8. Date of Birth (Month, Day, FCb2u424	Year)	inthplace (State or Foreign Country) MARY/ANG	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits	
	sho	5									1 ☐ Yes 2 No	
	the M	ect	MARYLAND HAR FOR		Bal Air	10f. Zip Code			140	og, Citizen of What (	,	
	a or	ă				,	مسره د		, ,	USA	Sourity:	
	eath	eral	816 Sidehill	12. Was Decedent E	verin U.S. 13 \	Was Decedent of Hi	spanic Orig	nin? (Spe	cify Yes or No-		nerican Indian,	
	ter d	Funeral Director	1 Never Married 2 Married	Armed Forces?		f Yes, specify Cubar	n, Mexican	, Puerto I	Rican, etc.)	Black, Wi		
3	urs a	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:			Specify: U	oh:te	
0	72 ho	ted	15. Decedent's E (Specify only highest gi	ducation	16a. Deced	dent's Usual Occupa	ition	t of worki	20	6b. Kind of Busines	s/Industry	
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+	life I	DO NOT use retired,	) ,	OF HOTAI	<i>'</i> 9	- 0	L	
2	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show avant, I're Medical Exscriter must be rediffed at	Completed	0	٥		INFA				INFA	N1	
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan nd Mental Hygjene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show maite avant, the Medical Exscrimental be rediffed at	Be	17. Father's Name (First, Middle, Las							Maiden Surname)		
<u>Ş</u>	s 1 and 2 should be Health and Mental itam 27 is marked o other traumatic ave	To		bhardt	105 11-103	- 4 - 1 (0 1 1	アル		SEAto		Zin Cordo)	
a	S 45 20 P		19a. Informant's Name/Relationship	(FAR	ENTO					City or Town, State	1	
	s 1 and 3 Health itam 27 other tr		FREGERICK And T.NA 20a. Method of Disposition	Gebhardt	20b. Place of Dispo	sition (Name of	()	RIVE.D			or Town, State	
20	Pages nent of l int: If its iry or o		1XBurial 2 ☐ Cremation 3 [	Removal from State	Holy Red G	natory or other place EMEK	e) A	PRIL	26 E	20c. Location - City of	City,	
altimore,			'4 □Donation 5 □Other (Spec. 21. Signature □ Service Lice		Ce	me tery_	s of Facilit	200		MARY	11420	
Ba	permit. Departr Importa any inji		1		S.	t. Joseph	medi	CAL	CENTER	لد ما معمد	21204	
	Physician /Medical		23a, Part . Enter the disease, or co	plications that caused to	the death. Do not ent					manyland	Approximate	
			shock, or heart failure. List only Immediate Cause (Final			TOBY CAT	11 1100	er sin			Interval Between Onset and Death 3 HOURS	
ř			disease or condition resulting in death)	a	RESPIRA consequence of):	TURT FH	LLLUPS				2 HOOKS	
	Examiner				URITY NO	N VIABIL	ITY				19 MIN	
L,		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c.									
Ö,	e exe ian a urial	I Ex	resulting in death) Last	Due to (or as a	consequence of):							
8760	cate be executed physician and the burial-transit	dical	•	d				·				
9	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of	of programmy					201.0		
Box	attend attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				23d. Date of o Month	Day Year	
o.	he de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	anie or death 3 E							
٥.	The law requires that the death certificate has been signed by the attending progge 2 should be detached for use as	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tob	23e. Did tobacco use contribute to the cause of dea			
Sp	uires sign d be	d by							1 □ Ye	s 2 <b>X</b> No 3□	Probably 4 Unknown	
00	w req	Completed							24a. Was a	n 24b. Were	autopsy findings available	
Re	The lay	duuc							autops perform	y prior t ned? death	o completion of cause of	
ta		Be Co	25. Was case referred to medical				26. Place	of Death	(Check only on	A	35 210110	
<u> </u>	ysician: is certific director,	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 patier	nt 2 ER/Outpatier	nt 3□ DOA Othe	ar.			nce 6 □Other (S)	pecify)	
0	ding Ph h. Alter th funeral		27. Manner of D ath	28a. Date of Injury (Month, Day	y 28b. Time of Injury	f 28c. Injury Work	at	2	28d. Describe ho	w injury occurred		
Division of Vital Records,	Attending Physician: r death sctor: After this certific by the funeral director,	atic	1 Natural 5 Pending 2 Accident investigation	on			Yes 2 🗌	No	4			
<u>S</u>	l or Attend after death Director: /	Certification:	3 Suicide 6 Could not determined		ry · At home, farm, str . (Specify)	reet, factory, office		1	28f. Location (St. City or Town	reet and Number or i, State)	Rural Route Number,	
	ital o irs aff ral Di led ir											
	To the Hospital or Attent within 24 hours after death To tha Funaral Director: completely filled in by the	edical	29a. Certifier 1 A Certifying P (Check only one) 2 Medical Exa	Physician: To the best of iminer: On the basis of and manner stat	examination and/or in	h occurred at the tim vestigation, in my or	ie, date an pinion, dea	d place, a th occurr	and due to the ca ed at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	1 - 22	(11)	\$9c. License	number		2	9d. Date signed (Mo	nth, Day, Year)	
)	11		3. A	. Linnar	(Hospita	D 20	2025			2/21/	06	
)(	3. K		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)	437	NE SE				
<u>( ·  </u>			ZEHRA SINNAR.	M.D. 976	Ø1 OSLER	DRIVE.	TOW	50N,	MARYL	AND 2120	714	
	Sta		31. Date filed (Month (DayOYear) 2	2006 32. Hispistra	r's Signature	OSAL)						
	Registi	ar		4	7	5.4						

		•	State of Maryland / Department  State of Maryland / Department  Certificate		⁄lental Hygie Reg.	211116	06324		
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month FEBRUARY	Day Year 15, 2006	3. Time of Death			
	/Medic			own, or Location of Death		4c. County of Deat	h .		
			Saint Joseph Medical Center	OWS			timore		
	Funeral Director		NONE YES.	Year If Under 24 Hrs. Days Hours Min. 2 5	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign nuntry) MARYLAND		
land	WO M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits		
e Mary	or 28a-f show e notified At	ctor	MARYLAND HARFORD BEL A'R				1 □ Yes 2 No		
with th	B or 28	Director	10e. Street and Number 10f. Zip C		10g.	Citizen of What Co	ountry?		
death	ems 23a or 28a-f sho	Funeral		21015 nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	nican Indian,		
72 hours after death with the Maryland	al', or Ite	by Fui	Armed Forces? If Yes, specifications of the forces of the forces of the forces of the force of t		o Rican, etc.)	Specify: Wi	e, etc.		
		eted	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	done during most of world	king 16I	o. Kind of Business	Industry		
filed within	r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Far-+		INFANT	+		
belil ed	d other tha	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Mai				
should		2	FREDERICK GEBNARdt	T:NA Street and Number or Ru	SEA ton		Zin Code)		
and 2 st	i thealth and Mer them 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) (PARENTS) 19b. Mailing Address (FREDERICK And TWA GEBHARDT 816 SID		BELA:A N		21015		
) -	of Health of tem 27 is		20a. Method of Disposition  20b. Place of Disposition (Name cemetery, crematory or oth	e of	Date 20d	c. Location - City or	Town, State		
t. Pages	Department of the Important: If ite any injury or of once.		'4 □Donation 5 □Other (Specify) CEMETER	Address of Facility	006	HIMERE	IANO		
	Depa Impo any ir		21. Signature of Eugeral Service Licensee 22. Name and St. Joseph	h medical Ca		of Osler mar	DR. UE 41204		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed by within 24 hours after death.  Whithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and point of the funeral director, page 2 should be detached for use as the burial-transit or page.	/	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.		or respiratory arrest		Approximate Interval Between Onset and Death EHRSSMIN		
		4	disease or condition resulting in death)  CARDIO RESPIRATORY FAILURE  Due to (or as a consequence of):						
Ε			IMMATURITY NON VIAI	BILITY					
Þ		Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause, Disease or injury						
execu		Exan	that initiated events ' c						
ate be		n/Medical	d						
certific			IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	ivery		
Te death		Physiclan/M	in the past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (special presents)			Month	Day Year		
s that t		by	Part II. Other significant conditions contributing to death but not resulting in the underlying car	use given in Part I.	23e. Did tobac	co use contribute to	the cause of death?		
equire					1 Tes	2 <b>X</b> No 3 □ Pi	obably 4 Unknown		
The law		Completed			24a. Was an autopsy performer	24b. Were at prior to death?	utopsy findings available completion of cause of		
		Be C	25. Was case referred to medical examiner?		th (Check only one)				
Physi		: To	1	c. Injury at	ome 5 Residence 28d. Describe how		cify)		
odina prina		atlor	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	Work? 1 ☐ Yes 2 ☐ No					
or Atte		Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,		
Hospits		Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
Tothe	within To the compl	Me		License number	29d.	Date signed (Mont	h. Day, Year)		
0	H		5. A Sennar - hospitalist	D 20025		-/15/0	6		
,0	. 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  7EHRA SINNAR, M.D., 7601 OSLER DRI	yE. TOWSON	. MARYLI	AND 2120	1 4		
	Sta Registr		31. Date filed (Month, Pay Year) 2 2006 32. Registrar's Signature	9					
	i icgisti								

CPM 06-01419 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Carl G. Hayes Amend Unpend item# 1,23a,77a perME / 85/4 4/6/06 TT health and Mental Hygiene For Amenditem#1, perME, 8854,4/19/00 TT Certificate of Death Reg. No. 1-2. Date of Death 1. Decedent's Name (First, Middle, Last) Carl C. 3. Time of Death Haves **Physician** Gilbert Hayes, Carl Gilbert Hayes, IV February 11:26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6005 Paternoster Lane Hughesville Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. No Verifice 1280 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1♥M 2□F 25 218-19-5354 Yrs. Director Washington, Usual Residence of Decedent tha Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow other than "natural", or Itams 23a or 28a-f ahovent, the Madical Examiner must be notified at 1 ☐ Yes 2 X No Hughesville Directo Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20637 US 6005 Paternoster Lane Α Funera Pages 1 and 2 should ba filed within 72 hours aftar death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ You
If Yes, Give A
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Electrican 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be n and Manta! I is marked or Cheryl Anne McCoy 2 Carl Gilbert Hayes. III 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Haelth 6005 Paternoster Lane, Hughesville, MD 20637 Carl Gilbert Hayes, III/father 20a. Method of Disposition 20b. Place of Disposition (Name of March 1 20c. Location - City or Town, State parmit. Pages 1 Dapartmant of H Important: If its any injury or ot once. 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2006 Leonardtown, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00641 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) nding physician and as as the burial-transit or Attending Physician: The law raquiras that the death cartificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical usa as tha IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s baan signe should be o Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 □ No certificata Yes 2 🗆 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Cother (Specify) XXYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day Year) : Aftar thi 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 5 Pending daath. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours aftar of To the Funaral Direct complataly fillad in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CKPLAC O.C.M.E. February 26, 2006 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 0 Tith 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 2 2006 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Year E 2006 12:52 PM 02 CMIOUT OST TELEN 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number, MONTGOMER GROVE ADVENTIST KOCKVILLE If Under 24 Hrs. 8. Date HOSPITAL If Under 1 Year 8. Date of Birth (Month, Day, Year) 02-21-21 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Deys NONE Yrs MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BOYDS 1XYes 2□No MARYLAND MONTGOMERY 10g. Citizen of What Country? 10e Street end Number 10f Zip Code 20841 USA TATAN DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Married 1□ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NFAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Lest) HOSTETLER USHOL 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TATANIDRIVE, BOYDS MARYLAND 20841 ATHER HOSTETLER 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2/27/06 GERMANTOWN, MD ALL SOULS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Uncensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as e consequence of)

Physician /Medical Examiner

ettending physician end I for use as the buriel-trensit

ste has been signed by the e page 2 should be deteched

the funeral director.

After this

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital or within 24 hours at To the Funeral D

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

Funeral Director

þ

Completed

Be

**Funeral** 

Director

Show

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryla Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show any injury or other traumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

death with the Meryland

Physician/Medical Examiner Completed by B 9 Certification:

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 TY65

25. Was case referred to medical examiner? 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death

1 XNatural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

28c. Injury at Work? 28b. Time of

1 🗌 Yes

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

29c. License number 063202

2 🗌 No

29d. Date signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No

21XNo

1 Yas

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name an address of pers of who of impleted cause of death (Item 23a) (Type, Print)

SGAH, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850 GILLIAN VACOB, MD 31. Dete filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

edicai

MAR 0



State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Kemper Hensley February 11, 2006 3:35 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Laurel Regional Hospital Prince George's Laurel Sex X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director July 4, 526-11-1818 52 1953 Virginia Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow other traumatic avant, the Madical Examinar must be notified at 10d. Inside City Limits 1 XYes 2 □ No Director Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8003 Mandan Road 20770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F ie markad of John Hensley Mary Ann Fox ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ie m any Injury or other traum Sanders Fox Haley/cousin 6806 Belford Drive Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 15, 2006 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <sub>b.</sub>Pneumonia Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed c Deep Venous Thrombosis Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anemia, depression, cachexia 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 XNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 DOA After the funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To tha Funeral Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Sertifying Physician: To the best of my knowledge, dauth occurred at the time, date and clade, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Diy, Year) 29c. License number D58683 30. Name and address of parson with completed cause of death (Item 23a) (Type, Print) E.G. 344 W. University BLVD. Suite 326 Silver Spring, MD 20901 Richard Akoto, M.D. 31. Date filed (Month, Day, Year) FEB 1 6 32. Poistrar's Signature State 2346 Registrar

			For State Registrar	State	of Marylar	•	artment of H		and Mer		ene 2006	06328		
			Decedent's Name (First, Middle	, Last)						Date of Death		3. Time of Death		
*	Physici /Medic		John Joseph	Hillman						Month bruarv	Day Yea 12 2006	5:30 pm M		
	Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, or	r Location o			4c. County of De			
-05		je y	10726 Autumn	Splendor	Drive		Columb				Howa	rd County		
	- Funeral		5. Social Security Number	6. Sex 1.2 <b>X</b> M 2F	7. Age (In yrs.		If Under 1 Year Months Days	If Under a	24 Hrs. 8. Min.	Date of Birth Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)		
do.	Director		578-50-0301	ILA-M ZUF	67	Yrs.			No	Month, Day, Vov. 22,	1938	New York		
	and		Usuel Residence of Decedeni  10a, State 10b, County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits		
	daryt a aho	ō	Maryland Howa	rd	C	olumbia	9					1 ☐ Yes 2 No		
	28a-	rect	10e. Street and Number				10f. Zip Code			10	g. Citizen of What	Country?		
	With Ba or	0	10726 Autumn S	Splendor	Drive		21044				USA			
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Mudical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed F	24□ No Sive		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin, Mexican	gin? (Specify 1, Puerto Rica	Yes or No- an, etc.)	14. Race - A Black, W SpecifyWh			
Ş	tura	edt	15. Decedent			16a. Deced	dent's Usual Occup	ation		11	6b. Kind of Busine	ss/industry		
5	in 72 n" r	Completed	(Specify only highes	t grade completed		(Give	kind of work done of OO NOT use retired	durina most	t of working			,		
72	l within liene.	E O	Elementary/Secondary (0-12)	5+	(1-4or 5+)	Phys	sicist				NAS	A		
b	I Hygie other	Be C	17. Father's Name (First, Middle, I	ast)				18. Mothe	er's Name (Fi	rst, Middle, M	aiden Sumame)			
<u>a</u>	Aental Aental rked c	To B	John A. Hillma	in				Eth	el M.	M. Weir				
Maryland 21215-0036	1 and 2 should be Health and Mental am 27 is marked other traumatic av		19a. Informant's Name/Relationsh Patricia A. Hil		fe		ng Address (Street Autumn				-	e, <i>Zip Code)</i> MD 21044		
re,	of Height		20a. Method of Disposition	- CD		Place of Dispo	sition (Name of matory or other place	:е)	Date		0c. Location - City	or Town, Slate		
Ë	Page Int.		4 Donation 5 Other (Specify) Gate of Heaven Cemetery 2006 Silver Spring, Mary											
Baltimore,	permit. Pages to Department of H Important: If Its any injury or ot		21. Signalure of Funeral Service	sicensee	· · · · · · · · · · · · · · · · · · ·	F1	rancis Address 00 Univer	ssets sity	ins Fu Blvd,	neral W., Si	Home Inc lver Spr	ing, MD 20901		
100			23a. Part 1. Enter the disease, of shock, or heart failure. List	complications that	caused the dea	th. Do not ent	er the mode of dyin	g, such as	cardiac or re	spiratory arres	st,	Approximate Interval Between		
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	acute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c		0								
30,	oe execian a	E	resulting in death / East	Due to	o (or as a conse	quence or):								
8760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	dicai		d										
9	eath certific attending p I for use as		IF FEMALE:	23c If yes o	utcome of pregn	ancy					22d Date of	dolivos		
Вох	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	aldeath 3□	Ectopic pregnancy Other (specify)	,			23d. Date of Month	Day Year		
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		JOE. 11	2 O ( ) ( ) ( ) ( ) ( ) ( ) ( )							
٥.	that the de ned by the a detached t	P	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.		23e. Did toba	acco use conInbut	e to the cause of death?		
Vital Records,	urres n sign	d by	Hypertension							1 🗌 Yes	s 2∱2 No 3 □	Probably 4 Unknown		
S	w requir been si should	lete								24a. Was an	24b. Were	autopsy findings available		
Re	The taw ate has b page 2 s	Completed								autopsy	ed? death	to completion of cause of 1? ∕es 2□ No		
a	(0	ပိ	25. Was case referred to medical					26 Place	of Death (C	1 ☐ Yes 2 heck only one		es 2 No		
>		0	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	00	•		nce 6 Other (S	ipecify)		
1 of		Ë	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o		y at			w injury occurred			
<u>o</u>	Attending Fire death.  ector: After by the funera	atio	1 Natural 5 Pendin 2 Accident investig	9	init, Day 1 Gar)	rigary		Yes 2	No					
Division	al or Attend after death   Director: / d in by the f	Certification:	3 Suicide 6 Could r	ned   200. Fla	ce of Injury - At h		eet, factory, office		28f.	Location (Stre City or Town,		Rural Route Number,		
Ö	talor rsaft alDia	Cer												
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		Examiner: On the			h occurred at the tin vestigation, in my o							
	To ti withi To ti comp	Ž	29b. Signature and title of dentities	10.0			29c. Licens	e number			d. Date signed (M	4		
	20		MACK	n M			D3	117	2	T.	Teb- 13	2006		
			30. Name and address of person Harry Oken, M.I					a, Ma	ryland			,		
	Sta Registi		31. Date filed (Month, Day, Year)	5 2005 32.	Registrar's Sign	ature	arte							

45	F	uner irect
*		irect
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denarment of Health and Mental Hydiene.	important: If tem 27 is marked other then "neturel", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at
)	Phy /M	sicia edic amin
18.	EXa	aman T
	ъ	=

÷		1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month		V	3. Time of Death
Physici /Medic		Marjorie	Rosa	Hershen	οW		Februa	ry 17,	2006	2:16 a.r
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of Death	1	4c. Count	of Death	
		St. Mary's Nu				onardtown		St.	Mary'	S
Funeral		5. Social Security Number 6. Sec	144 0000	vrs. last birthday, Yrs.	If Under 1 Ye Months Da		8. Date of Birth (Month, Day July 24	Year)	9. Birthp	elace (State or Forei nto) Íornia
Director		572-66-1267 Usual Residence of Decedent	3M 2LAF 85	113.			July 25	+,1920	Call	TOTILA
ehow		10a. State 10b. County	10c.	City, Town or L	ocation		•		1	0d. Inside City Limit
Mary i-feh	ţ	Maryland St. Mary'	s S	t. Mary	s City					Yes 2□N
r 28a	Directo	10e. Street and Number			10f. Zip Cod	ie		10g. Citizen of	What Cour	itry?
72 hours after death with the Maryland neture!; or items 23a or 28a-1 show dical Examiner must be notified at	O E	17722 Rosecroft Ro	ad		2068	36		United	Stat	es
deat	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-	14. Ra	ce - Americ	
or it		1 Never Married 2 Married	1 ☐ Yes 2 🎇 No If Yes, Give		1 ☐ Yes 2 <b>∑</b>			Specia		hite
72 hours "neturel",	d by	3 Widowed 4 Divorced	Year or Dates:	100 David						
39	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Oc kind of work do DO NOT use re	one during most of wor	king	16b. Kind of E	on stues syllic	Justry
then.	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	Libra				Libr	arv	
2 should be filed within and Mental Hygiene. is marked other then aumatic event, the Marken auma		17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,			
ld be ental kad ic ev	To Be	Arthur Charles Bud	d			May M. K	innear			
should ind Men marks	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mail	ng Address (Str	eet and Number or Ru	rai Route Numbe	r, City or Town	, State, Zip	Code)
and 2 ealth a m 27 is		Margaret Ann Carlt	on/ Daughte:	r P.O.	Box 228	St. Mary'	s City M	larylan	d 206	86
of He of He		20a. Method of Disposition		b. Place of Disp cemetery, cre	osition (Name or matory or other	f place)	Date	20c. Location	- City or To	wn, State
Pages nent of ant: If Its		1 ☐ Burial 2 【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	B:	rinsfiel	d-Echo1	s Cre 2-21	-2006	Charlo	tte H	all, MD.
permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny injury or other traumatic 200ce.		21. Signature of Funeral Service Licens	88 / 7 Le	man 2	2. Name and Ad	dress of Facility Br	insfield	l Funer	al Ho	me PA.
3 89E 28		Kyle S. Simons				11ywood Rd			Mary	1and 2065
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the c ne cause on each line.	leath. Do not en	ter the mode of	dying, such as cardiac	or respiratory ari	rest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Ventria	ulas	anut	hmia				Oriset and Death
/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):	, J					
Lxammer		Sequentially list conditions,	Corona	ing A	Lery	Brease				
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence or):	1/	Dys Ru	2.		İ	
xecut and II-tran	хап	that initiated events resulting in death) Last	Due to (or as a con	sequence of):	10 sale	Lys Fur	Man			
icate be executed physicien and sthe burial-transit		l l	No.	L.						
ficate p phys	edic			110						
eath certifica attending pt	clan/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre		7-			23d. Da	ate of delive	ary
death e atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐F 4☐Pregnant at time		∃Ectopic pregna ∃Other (specify			М	onth	Day Year
it the by th	Physic	9 🗆 Unknown	9□ Unknown							
w requires that the do been signed by the should be detached	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the	inderlying cause	given in Part I.	23e. Did to	bacco use cor		ne cause of death?
en sig		the pertension	~	· ·			1 🗆 Y	'es 2□No	3 Prob	pably 4 Unknow
law ras be	ple	- Dochstee W	ellitus				24a. Was a autop		Were auto	psy findings availab
The I	Completed						perfor	med?	death? 1 ☐ Yes	
cian: ertific	Be (	25. Was case referred to medical examiner?					ith (Check only or	ne)		
hysi this c	ဥ	T Tes 209No		2 ER/Outpatie	III JUDON		ome 5 Resid			у)
Ing P	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time (		njury at Work?	28d. Describe h	low injury occu	rred	
tend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home form		1 ☐ Yes 2 ☐ No	39f Location (S	Stroot and Num	hor or Pum	al Route Number,
or A after Direction by	ertif	4 ☐ Homicide determined	building, etc. (Sp	pecify)	reet, ractory, on	ice	City or Tow	vn, State)	Dar or Hore	u rioute ivalibel,
spitel ours neral filled		29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge, dea	th occurred at th	e time, date and place	and due to the o	cause(s) and m	anner as s	tated
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit	edical	(Check only 2 Medical Exami	ner: On the basis of exame and manner stated.	nination and/or ii	vestigation, in r	ny opinion, death occu	rred at the time, o	date and place	and due to	the cause(s)
To th Mithin To th	Me	29b. Signature and title of certifier			29c. Lic	cense number	- 2	29d. Date sign	ed (Month,	Day, Year)
, ,, ,		* ARA M	93		DS	56 21-1		2/1-	7/0	~
		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	Print)				1104	MD 20103
		Archana Grup	ta, MD	24035	Three	Notch	Rel H	ollyw	bod.	MD
Sta		31. Date filed (Month, Day, Year) FEB 2 1 20	3 Aegistrar's S	ignature	. فد		, .	Ú -		
Registr	-	I PR H I CO.	- JOURS	Sie Age	العاد					
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			1 - For State Ragistrar	State of Marylan	-	artment of I tificate of			jiene leg. No.	006	06330
П	Physici	an	Decedent's Name (First, Middle, Last		1 . 1			2. Date of Dea Month JANUARY		Year	3. Time of Death
	/Medic Examir	cal	ANGELO ChRIS 4a. Facility Name (If not institution, give Saint Joseph			4b. City, Town,	or Location of Dea	ıth .	_	2006 County of Death Balti	1:47 FM
	Funeral Director		NOVE	ex M 2□F	last birthday) Yrs.	If Under 1 Year Months Days	Hours Mir		, Year)	Cour	place (State or Foreign ARY AND
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
	ter deeth with the Marylar Itema 23a or 28a-1 show institutet et motified at	to	MARYLAND	BAI	timore	E City					1 Yes 2 □ No
	or 28	Funeral Directo	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	a 23a	eral	7021 Gough Stree	12. Was Decedent Ever in U.	e   12 \	212		Specify Vas or No-	1	USA 4. Race - Americ	an Indian
350	72 hours after deeth with the Maryland natural; or itema 23a or 28a-f ahow dical Examinat must be motified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cub		Specify Yes or No- rto Rican, etc.)		Black, White,	etc.
2-0036	72 hou		15. Decedent's Ec		16a. Deced	lent's Usual Occu	pation during most of w	orking		d of Business/In	
	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	ed)	orking	I	ofant	
2	Hygie other	60	17. Father's Name (First, Middle, Last)		-	Z/O(A/O)	18. Mother's Na	ame (First, Middle,		****	
Vlan	Mentel Mentel Arked artic av	To B	Kosta Hariti	dis							
Man.	12 sho		19a. Informant's Name/Relationship (					Rural Route Numbe		9	
ē,	s 1 and f Health Item 27 other t		MARY AND KOSTA HAR 20a. Method of Disposition	20b. P	lace of Dispo	Gough 5 sition (Name of		Date	20c. Loc	tation - City or To	1224 own, State
altimore,	0 0 = 5		Burial 2 Cremation 3 4 Donation 5 Other (Specific	Hemovai from State		natory or other pla MER CE	ice)				y, maryland
<u>=</u>	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Licer				ess of Ficility	Center	271111	710.2	Y MAKY MAKE
מ	80 E 2 9		Janelle	7	176	DOI OSIER	DRIVE	TONSON, MI		nd 212	
	Physician		23a. Part . Enter the disease, or com shock, or heart failure. List only lamediate Cause (Final disease or condition	plicates that caused the death of the course on each line.  EXTREME PR				ac or respiratory and		4 14	Approximate Interval Between Onset and Death IINUTES
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as a consequ	uence ol):					_	
	ecuted and transii	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c							
8/60,	centificate be executed iding physicien and ise as the burial-transit	cal E	rosaning in osani, zasi	Due to (or as a consequ	uence oi):					13	
280	ate hy:	<b>-</b>		. d							
X D	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna		Ectopic pregnanc	ev.		2	3d. Date of delive	•
-	the death or the attention to the differ u	Physician/Me	1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown	eath 5□	Other (specify)				Month	Day Year
s, T	es that gned b	þ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	1	/	he cause of death?
ecord	> ~ 0	eted						24a. Was a	_/	, -	psy findings available
Ĕ	e la hes e 2	Completed						autop perfor	sy	prior to co death?	mpletion of cause of
Vital H	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?					eath (Check only or			7
5	this al di	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 X npatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ry at ork?	Home 5 Resid			(y)
Division	al or Attanding F after death. I Diractor: After d in by the funer	licat	Z Accident investigation 3 ☐ Suicide 6 ☐ Could not be	B 280 Blood of Injury At he	ome, farm, str		]Yes 2□No	28I. Location (S	treet and	Number or Rura	al Route Number.
2	s after al Dira	Certification;	4 Homicide determined	building, etc. (Specify	()	,,		City or Tow	n, State)		,
	ha Hospital or Attand in 24 hours after deatl ha Funeral Diractor: pietely filled in by the	ledical (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kno- niner: On the basis of examinat and manner stated.	wledge, death tion and/or in	occurred at the treatment occurred at the treatment of the treatment of the treatment occurred at the treatment occurred a	ime, date and plac opinion, death occ	ce, and due to the courred at the time, o	ause(s) a	and manner as s place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Licen	se number	1		signed (Month,	Day, Year)
) 1			( Julies a	euson			036836		02/	3/06	
5.1	1		30. Name and address of person who				Flore of the last Free	(*) k.1	VI /51	Egins on anyone and	
	Sta	ite	31. Date filed (Month, Day, Year)	N. M. D. 760 32. Registrar's Signa	ture	195	JE TOWS	UN, MAK	Y L.FIN	ND 2204	·
	Registr		MADAS	2006	K & A	melis					

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H			ene 2.006	06331
E AND			Decedent's Name (First, Middle, Landson L	ast)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Mary E	stelle	Hyde			FEBRUAR		5 5:20 a M
Or I	/Medic		4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death		4c. County of Dea	th
	LXamin	š .	St. Mary's	Hospital			ardtown		St. Mai	
	Funeral		5. Social Security Number 6.	Sex 7. Ac	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		218-20-1424	1 □ M 2 🛣 F	81 Yrs.			Nov. 13	,1924 Mai	cyland
	D >	-	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	sho	5	,			Dame	ron			1 ☐ Yes 2 🛣 No
	28a-f	Director	Maryland St. M	ary s		10f. Zip Code	LOII	10	g. Citizen of What C	ountry?
	a or			bach Road		206	28	1	United Sta	atac
	eath	era	1012/ 11055	12. Was Decedent	t Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba			14. Race - Am	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iteme 23s or 28s-1 show any injury or other treumatic event, Ite Madical Examinating the notified at once.	by Funeral	1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	Armed Forces  1  Yes 2   If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 X No	in, Mexican, Puerto Specify:	Hican, etc.)	Black, Whi	white
Baltimore, Maryland 21215-0036	72 hour natural		15. Decedent's I	Education	16a. Dece	dent's Usual Occup	during most of work	ing	6b. Kind of Business	/Industry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired	1)		Own Ho	m A
21	led w lygier her th	ပိ	7 17. Father's Name (First, Middle, Las	211	Н.	omemaker	18. Mother's Nam	e (First, Middle, M.		iie
n o	be fi	Be						Goldsmi		
<u> </u>	d Mer nark	2	James H. Go		19b Mail	ing Address (Street			City or Town, State,	Zip Code)
Ma	d 2 st th and 7 ts n treur		Charles Louis Tr			-				
<u>ရ</u>	1 and Heali		20a, Method of Disposition	ossbacii/ F	20b. Place of Disp	osition (Name of		Date 2	Oc. Location - City o	r Town, State
Ö	nt of nt of r: ###		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		8	matory or other place ae1's Cem		-2006	Ridge, Ma	rvland
Ħ	artme ortani inlury		21. Signature of Funeral Service Lic						Funeral H	
Ba	Dep Impe sny		Edward N. Brinsf							D 20650-0279
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each	line.		ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a	estre si	1004				
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):					
200	LAGITITICI	_	Sequentially list conditions,	b. Due to for a	as a consequence of):					
	pe tis	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C	HF					
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last		s a consequence of):					
8760,	be e sician buria			HY	for culce?	mig				
687	ficate physics the	op o		d						
) X	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of d	
Box	death a atter	Cla	in the past 12 months?	4 Pregnant	at time of death 5	□Ectopic pregnanc □ Other (specify)	y 		Month	Day Year
P.O.	t the c by the ache	hys	9 Unknown	9□ Unknown						
	The law requires that the death certific sie has been signed by the atlending p bage 2 should be detached for use as i	þ	Part II. Other significant conditions	Contributing to death H4P3 H	but not resulting in the	underlying cause giv	ven in Part I.			to the cause of death?  Probably 4 Dinknown
HYDE ecords,	v req been shou	Completed	·DVI		,			24a. Was ar		autopsy findings available
H W	icien: The lav certificete has rector, page 2	E D						autopsy perform 1 Yes 2	ned? death?	
ESTELLE of Vital R			25. Was case referred to medical				26. Place of Dea	th (Check only one		2.00
S.E.	Physicien: this certificated director,	To Be	examiner?	Hospital: 1 Inpa	atient 2 ER/Outpatie	ent 3 DOA Ott	0.00		ence 6 Other (Sp.	necify)
_			27. Manner of Death	28a. Date of In (Month, L	njury 28b. Time Day Year) Injury		ry at	28d. Describe ho	w injury occurred	
MARY	Attending ir death. ector: Afte by the fune	ate	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigat	tion			Yes 2 □No			
MARY Division		ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace UI	Injury - At home, farm, s etc. (Specify)	street, factory, office		28f. Location (Sti City or Town	reet and Number or . n, State)	Rural Route Number,
Ö	Hospitel or Attena 4 hours after deatl Funerel Director: tely filled in by the	0								
1	To the Hospitel within 24 hours a To the Funerel I completely filled	ledical	29a. Certifier National Certifying (Check only one)	Physician: To the be caminer: On the basis and manner	st of my knowledge, dea of examination and/or stated.	atn occurred at the ti investigation, in my	me, date and place opinion, death occu	red at the time, da	ause(s) and manner ate and place, and d	ue to the cause(s)
2	To the Hos within 24 hr To the Fur completely	Me	29b. Signature and title of dertifier				se number		9d. Date signed (Mo	/
	. > - 0		· ~	~~	1 am	700	06221	>	2/10/0	6
			30. Name and address of person w	ho completed cause o	of death (Item 23a) (Type	e, Print)				
_			DR SURESH H PA	TEL SHAH	ASSOC HOLL	YWOOD MD	20636			
		ate	31. Date filed (Month Day Year)	2006 32. Pgi	strar's Signature	hacks				
	Regist	Tal								

			1 - For State Registrar		of Ma	ryland				ealth a	and M	lental Hy	Reg. No.	no	16	06332
	Physici		1. Decedent's Name (First, Middle, Cecelia Isaac									2. Date of De Month Februa:	Day	. 2	Year 2006	3. Time of Death  10:55A M
16	/Medic Examin	_	4a. Facility Name (If not institution,		mber)			4b. City,	Town, or	Location o			-		y of Death	
5			Collingswood Nu						kvill					ntg	omer	
	Funeral Director		199-12-8319	3. Sex 1 □ M 2 🖾 F	7. Age 8		st birthday) Yrs.	Months	1 Year Days	If Under: Hours	Min.	8. Date of Bir 12/9/	1918		9. Birth PA	nplace (State or Foreign untry)
	and and		Usual Residence of Decedent  10a. State 10b. County		T	10c. City,	Town or Lo	cation								10d. Inside City Limits
	Maryl	tor	MD Montgo	nery	:	Rockv	ville									1X Yes 2 □ No
	th the or 28s	irec	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of	What Cou	untry?
	eth wi	ral	299 Hurley Aven						350				USA			
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow enty injugy or other traumatic event, Ira Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 🏿 Widowed 4 □ Divorced	12. Was Dec Armed F d 1 □ Yes If Yes, G Year or I	orces? 2⊠No ive			Was Dece fYes, spe 1 ☐ Yes	offy Cuba	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	D-		ick, White	ican Indian, , etc. hite
21215-0036	thin 72 ho e. en *natur Madical	Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2				16a. Deced (Give life. L	ient's Usu kind of wo DO NOT u	rk done a	lu <i>rina mos</i> t	t of worki	ing	16b. Ki	nd of B	Business/h	ndustry
2	lled wi lygier her th	Cor	17. Father's Name (First, Middle, L	201)			secr	etar	7	19 Motho	r's Name	e (First, Middle			nmen	t
and	d be fi	o Be	Benjamin Neiman	<b>15</b> ()								utsch	, Maiuen	Sumar	тө)	
Maryland	should nd Me mark umatic	To	19a. Informant's Name/Relationshi	p (Type, Print)			19b. Mailir	ng Address	(Street a			or Rural Route Number, City or Town, State, Zip Code)				
Ž	and 2 saith a n 27 is er tra		Judy Braunstein	-daughte	•		8549	Bauer	Cir	cle	Spr	ingfiel				
Baltimore,	Pages 1		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.		cen	ce of Dispo netery, cren Lebar	natory`or o	ne of ther place		2/13	) / 06				Town, State	
Balti	permit. Departm Imports eny inju		21. Signature of Funeral Service L	Stot	ten	negel	Ch	.ape⊥s	5 II	./U Ro	ockv:	ille Pi	tory arrest, Approximate Interval Betwee Onset and Dea			
8760,	Physician /Medical Examiner and physician and physician and the pnual-transit the pn	licai Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading or immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Con Due to b. Hyr tous to	ngest (orasa (orasa (orasa cial	tive conseque ensio	Heart once of): on illat	Fail								Interval Between Onset and Death 5 Years 15 Years
P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		birth 2 nant at ti	of pregnance Pi∏Fetal d ime of dea	leath 3□	Ectopic p Other (s,					2		ate of delive	very Day Year
Records, P	uires that signed b ld be det	by	Part II. Other significant condition Diabete		leath but	t not result	ting in the u	nderlying o	ause give	en in Part I.			tobacco u Yes 2			the cause of death?
COL	aw require s been si s should t	Completed	Pneumo	nia								24a. Was		24b.	Were aut	opsy findings available
Be	The lav	mo										auto perfe	psy ormed? 24 No		death?	ompletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			100		of Death	Check only							
Division of Vital	Afte	tion: To	1 ☐ Yes 2 ∑ No  27. Manner of Death  1 ∑ Natural 5 ☐ Pending 2 ☐ Accident investigat	R/Outpatien 28b. Time of Injury		8c. Injury Work	4 100 140		me 5 Res 28d. Describe				ify)			
Divis	tel or Attend rs after death el Director: / ed in by the f	Certification:	3 Suicide 6 Could no 4 Homicide determin	ne, farm, str	eet, factor	y, office			28f. Location ( City or To	Street and wn, State	d Numi )	ber or Rui	ral Route Number,			
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	7		/ / / / •						D005	3015			Febr	uar	у 13	, 2006
	·		30. Name and address of person w	nan, M. 1	0. 1	1125	Rockv		Pike	, # 2	208,	Rockvi	11e,	Ma	ry1aı	nd 20852
	Sta Registr		31. Date filed (Month, Day, Year) FEB 15	2006	Hegistra	r's Signatu	dos.	we								

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1)

AMENDA	719a :		H. AACO HEALIH DE		/06 CMH	<i>Ce</i>	rtificate	e of L	Jeath		Reg. No.		
Dhu	cician	1. De	cedent's Name (First, Middle,	Last)						2. Dete of De Month	ath Day	Yeer	3. Time of Death
	sician edical	BF	UCE JEFFERSON	N						FEBRUA	RY 10.	2006	3:35PM
	miner	4a Fe	cility Neme (If not institution,	give street end	number)			4	b. City, Town, or L	ocation of Deet	h 4c. Co	unty of Deet	h
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			KIN-CHASE NURS	6. Sex		rs. lest birthday			If Under 24 Hrs.	8. Date of Bir (Month, Da			hplece (State or Foreign untry)
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be filed within 72 hours after death with the Maryland tal Hygiene.  or other than "natural", or items 23s or 28s-f show account its markets.	Funeral		82 PATUXENT R		Decedent Ever in	U.S. 13		1035	spenic Origin? (Sa	pecify Yes or No		D STA	rican Indian,
ar d	Š	1	aritel Status	Armed	Forces?	0,0.	If Yes, spec	cify Cuba	spenic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		Black, Whit	e, etc.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 1321 M 02 lò 06 Mae U1a Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heart Allegany Sacred Hospital Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 ☐ M 2 🗓 F Months Davs 78 Director 216-22-6961 04/05/1927 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director MD Allegany Cumberland 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? or iteme 23a or 12916 N. Cresap Street, #3 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: þ 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) 9 Seamstress Clothing Factory permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if item 27 te marked other eny injury or other traumatic event, I 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Branson Albert Heavner Mary Ethe1 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Johnson / husband 12916 N. Cresap Street, #3, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/14/2006 Hillcrest Mem. Park Cumberland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. PDC8 404 Decatur Street, Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KESPIRATORY FAILURE Physician 24 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner ATELECTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) DIVERTICULITIS WITH PERFORATION igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.0. 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manper of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 1 Naturaf 5 Pending NONE м 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of pertities 29c. License number 29d. Date signed (Month, Day, Year) M.D )59249 who completed cause of death (Item 23a) (Type, Print) 30. Name and aderess of oerson DRIVE Cumberland MD nas DANA 31. Date filed (Month, EB 1 3 2006 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 21 per fh 9853 3-2-06 vt.

State of Maryland? Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 7:05 22, MILDRED ELIZABETH KONCER FEBRUARY 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death WASHINGTON HAGERSTOWN AVALON MANOR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days Hours Min 1 ■ M 2 XF 91 Yrs 1914 WEST VIRGINIA 232-32-5229 JULY 10, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1XXYes 2 □ No HAGERSTOWN WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13802 BROADFORDING CHURCH ROAD 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) RESTAURANT BUSINESS OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SUSAN FRANCES STUMP PRICE WILLIAM G. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13802 BROADFORDING CHURCH RD. HAGERSTOWN, MD 21740 FRANCES ANDERSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 urial 2 Cremation 3 Removal from State MARTINSBURG, WV ROSEDALE CEMETERY 2/24/06 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee John L. Attilli per dvr 917 CEMETERY RD. MARTINSBURG, WV 25401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ension YPRN Due to (or as a consequence of): Melitus c-Ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 1 that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Examiner burial-transit The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical thet use as ţ be detached ģ peeu has page certificate Physician: funeral director, 5 After or Attending within 24 hours after death. To the Funeral Director: A the filled in by Hospital completely

2

Completed

Be (

Certification: To

Medicai

29a. Certifier

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Exacution titual be notified at

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permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygiend Important: If Item 27 Is marked other the any illury or other traumatic event, the ans.

Physician /Medical

Examiner

Director

Completed by Funeral

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the Maryland

death

within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31 Date filed (Month, Day, Year) 2006

FARIO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1126

29c. License number

0060396

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245+0Wh

29d. Date signed (Month, Day, Year)

2/22/06

MA

**ORIGINAL** 

			For State Registrar	State of Ma	ryland /		irtment of H tificate of I			giene Reg. No.	06	06336
	Physici	an	Decedent's Name (First, Middle, and American State						2. Date of De Month		Year	3. Time of Death
,	/Medic	al	Sara 4a. Facility Name (If not institution, g	Ruth give street and number)	Kesr	ner	4b. City, Town, or	Location of Deat	th	4c. Co.	anty of Death	
			13728 Spruce S				Cresapt				gany	
	Funeral Director		220-28-9964	10M 2GE	(In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da Jun 20	), <b>19</b> 33	9. Birth	hplace (State or Foreign unity) MD
	land ow		Usual Residence of Oecedent  10a. State 10b. County		10c. City, Tox	wn or Lo	cation					10d. Inside City Limits
	e-f eh	ctor	MD Alleg	any	C	Cresa	aptown					1 X Yes 2 □ No
	3a or 28	i Dire	10e. Street and Number 13728 Spruce S	pring Road			10f. Zip Code	21502		10g. Citizen	of What Co	untry?
	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "naturel", or Iteme 23a or 28e-f ehow aumatic event, the Medical Examinating the notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent E Armed Forces?		į.	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (§ n, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. [	Race - Ame Black, White	
903	urel', or	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			☐Yes 2🖔No	Specify:			ecify: wh	
21215-0036	nin 72 t in "natu Medica	Completed	15. Decedent's (Specify only highest : Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5-		(Give	lent's Usual Occupa kind of work done o DO NOT use retired	during most of wo	orking	16b. Kind o	of Business/I	Industry '
2	filed with Hygiene other the	Com	12	-	aid	de		40 14-15-1-1	me (First, Middle		g hom	ne
aryland	uld be fi Mental H irked oth	To Be	17. Father's Name (First, Middle, La Britt Buckalew						(Hansel)			,
Mary	nd 2 sho lith and ! 27 is ma r trauma		19a. Informant's Name/Relationship Marjorie Llewelly				g Address <i>(Street a</i> KSON Mt. F			er, City or To Coning		Zip Code) ID 21539
altimore,	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: If Item 27 is marked eny injury or other traumatic es ance.		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3		cemete	өгу, стөп	sition (Name of natory or other plac lemorial Pai		Date 2/26/2006		on - City or <sup>*</sup>	Town, State
	permit. Pi Depertme Important eny injury ance.		4 Donation 5 Other (Spe		11000		Name and Address Scarpel			1103	burg	IVID
<b>6</b> 0	20559		23a. Pag / Enter the disease, or co	omplications that caused	the death. Do		108 Virg	jinia Aveni	ue: Cumbe		ID 2150	Approximate
7	Priysician	6.74	23a. Part Enter the disease, or construct, or heart failure. List or Immediate Cause (Final disease or condition	Materi	ahic	Real		Cinma		,		Interval Between Onset and Death 2 Mos
	/Medical Examiner		resulting in death)	Due to (or as a	-	of):						
	ted sit	niner	Sequentially list conditions, if any, leading to immediate the second control of the cause (Disease or injury	b. Due to (or as a	consequence	of):						
v Ö	icate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):						
58760,		edicai		d								
Box (	es that the death certifing gned by the attending be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal deat		Ectopic pregnancy			23d.	Date of deli	ivery Day Year
P.O. Box	t the de by the a ached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	ime of death	5	Other (specify)					
	The law requires that the site hes been signed by the bage 2 should be detache	by	Part II. Other significant condition	s contributing to death bu	t not resulting	in the ur	nderlying cause give	en in Part I.		obacco use o	-	o the cause of death? obably 4  Unknown
ecor	e law requir hes been si je 2 should l	Completed							24a. Was	an 24	4b. Were au	stopsy findings available completion of cause of
E E	ysicien: The lis certificate he director, page								perfo 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 No
5	ysicier s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/C	outpatien	t 3 DOA Othe	0.0	ath (Check only only only only only only only only		Other (Spe	cify)
n of	ing Phy After thi uneral c		27. Manner of Death 1. ■Natural 5 □ Pending	28a. Date of Injury (Month, Day		Time of Injury	28c. Injun World	at k?	28d. Describe			,
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be One Disease (Jain	ry - At home, t	farm, stre		Yes 2 □ No	28f. Location ( City or To		<i>ımber</i> o <i>r R</i> u	ıral Route Number,
۵	pitel o		29a. Certifier W Certifying	Physician: To the best of		no doath	accurred at the tim	and and place			1	cotate d
	he Hos in 24 hc he Fun pletety	Medicai	(Check only 2 Medical Exone)	caminer: On the basis of and manner star	examination a	ind/or inv	estigation, in my of	pinion, death occ	urred at the time,	date and pla	ce, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1	7		29c. License					h. Day, Year)
	4		30. Name and address of person wi	no completed cause of de	ath (Item 23a	) (Type.	Print)	59987		2/2-	7/06	
	`		902 Seton Driv	e Suite 30:	3 6	mi	berland,	UD 21	503			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2	32. Registra	r's Signature	A	Print) per/and, 1					•

		For State Registrar	State of Mary	land / Depa	artment o	f Health and North	Mental Hy	giene Rag. No. ()	06337
Physicia /Medica Examine	al	Decedent's Name (First, Middle, Last)     James Michael Klin     A. Facility Name (If not institution, give s			4b. City, Tow	m, or Location of Death	2. Date of De Februar		Year J. HD J M y of Death
Funeral Director		Doctor's Community 5. Social Security Number 6. Sex 150 150 150 150 150 150 150 150 150 150	7. Age (In	yrs. last birthday) 54 Yrs.	Lanham If Under 1 Y Months Da		8. Date of Bi		9. Birthptace (State or Foreign Country) Pennsylvania
with the Maryland a or 28a-f show Le rollied at	ector	Usuat Residence of Decedent 10a. State 10b. County  Maryland Prince Ge		c. City, Town or Lo Bowie					10d. Inside City Limits 1 <b>X</b> Yes 2 □ No
or death	y Funeral Director	1 ☐ Never Married 2 X Marned	2. Was Decedent Ever Armed Forces? 1 MYes 2 □ No If Yes. Give		10f. Zip Cod 2071. Was Decedent if Yes, specify of	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No Bican, etc.)	USA	What Country?  ce - American Indian, tck, White, etc.
/land 21215-003 uld be filed within 72 hours Mental Hygiene. riked other than "natural, ulic event, the Mudical Ext	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	60- '64  16a. Deced (Give life.	dent's Usual O	ccupation one during most of won	kıng	16b. Kind of B	White Business/Industry
laryland 2121 2 should be filed within and Mental Hygiene. ie marked other than eumatic event, Italy	To Be Co	17. Father's Name (First, Middle, Last)  John Kline	3	NSA		18. Mother's Nam Bessie I	Doughert	a, Maiden Sumai ty	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other treumatic event, Ita Madical Examinar monatics collided at once.		19a. Informant's Name/Relationship (Typ.  Judith Kline/ Wife  20a. Method of Disposition  1∑ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	emoval from State	12031 Place of Dispo cemetery, cres Mary Veterans	Twin sition (Name of matory or other 71 and Cemete 2. Name and A	rv 02/1	Bowie, Date 17/2006 Dert E.	MD 2071 20c. Location Crownsv Evans F	-City or Town, State rille, Maryland 'uneral Home
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e cause on each line.	death. Do not ent	er the mode of		or respiratory a	arrest,	Approximate Interval Between Onset and Death  (M turn)
76( te be ysicie	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a co	regnancy ]Fetal death 3[	⊒Ectopic pregin				ate of delivery onth Day Year
	Completed by Phy	9 □ Unknown  Part II, Other significant conditions con		ot resulting in the u	nderlying caus	e given in Part I.	1 24a. Was	Yes 2 □ No s an 24b.	atribute to the cause of death?  3 Probably 4 Monknown  Were autopsy findings available prior to completion of cause of
n of Vital ng Physician: ter this certifica	To Be	25. Was case referred to medical examiner? 1 Yes 2 5 No  27. Manner of Death 1 5 Pending	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	ER/Outpatier 28b. Time o		26. Place of Dea Other: 4 Nursing H	1 ☐ Yes ath Check on V ome 5 ☐ Res	orned? 2 No one sidence 6 Ot how injury occu	
Division  To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, str Specify)	M reet, factory, of	1 Yes 2 No		(Street and Num own, State)	ber or Rural Route Number,
he Hospit: in 24 hours he Funere pletely fille	Medical (	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of mar: On the basis of exa and manner stated	amination and/or in	h occurred at ti vestigation, in	he time, date and place my opinion, death occu	, and due to the rred at the time	e cause(s) and m , date and place,	nanner as stated. , and due to the cause(s)
To ti within To the	×	29b. Signature and titte of certifier	- mo		me	10 556 97		29d. Date signs	ed (Month, Day, Year)
Sta	te_	30. Name and address of person who co  OK* TUON - AM VU  31. Date filed (Month, Day, Year)	mpleted cause of death  575 / Registrar's	win Stree	Print) T Sign	Te 351, Lau	irel m	D 2070	7
Registra		FEB 1 5 2006	TAR.	Mr Box	red o				

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma		ertificate of I	lealth and Mer <i>Death</i>		ene 0 0 6	06338
			1. Decedent's Name (First, Middle, L	ast)			2.	Date of Death Month	Day Year	3. Time of Death
	Physicia		Mae	Irene		Kreger	F	`ebruarv		8:45 A M
	/Medic Examin		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, Town, or	r Location of Death		4c. County of Deat	h
			Frostburg Villag	e Nursing H	Home	Frostbu	ırg		Allegan	
	Funeral			Sex 7. Age	(In yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Y	(ear) 9. Birti	hplace (State or Foreign untry)
	Director		214-07-4628	1□ M 2∏F	96 Yrs.		0	9/26/19	09 Mar	y land
	D P	-	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or I	ocation	<del></del>			10d. Inside City Limits
	sho	7			•	umberland				1 ☐ Yes 2 ☐ No
	he M	Director	MD All e	egany		10f. Zip Code		100	J. Citizen of What Co	untry?
	with t						0.0		-	•
	s 23	eral	12805 McMu1.	en Highway	ver in U.S. 13	Was Decedent of H		v Yes or No-	USA 14. Race - Ame	rican Indian,
	iter d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N	lo		fispanic Origin? (Specifian, Mexican, Puerto Ric	an, etc.)	Black, White	e, etc.
38	irs af	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: W	hite
21215-0036	72 hours after death with the Maryland naturel; or items 23a or 28a-f show Jisal Examiner must be natified at	Completed	15. Decedent's	Education	16a. Dec	edent's Usual Occup	pation during most of working	16	3b. Kind of Business/	Industry
715	hin 7.	ple	(Specify only highest g	College (1-4or 5-	life.	DO NOT use retired	d)			
7	d with	NO.	12			Homemaker			Home	
b	al Hy l oth	Be (	17. Father's Name (First, Middle, Las	st)			18. Mother's Name (F			
Maryland	Ment Ment arked	은	Joseph	Wallace	Coll			Belle		avis
lan	2 sho and Is my		19a. Informant's Name/Relationship				and Number or Rural F			
	and salth n 27		Colleen Grayson	/ daughter		) 3 McMulle  position (Name of rematory or other place	en Hichway,		land, MD	21502
ore	of H		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	l .		,				
Ē	Pag ment ent: ury c		` 4 □ Donation 5 □ Other (Spec	and the same of th	The second secon	umberland				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other treumatic event, if is the cited Examiner must be notified at once.		21. Signature of Fureral Service Lice	ess of Facility Adam cur Street,		•	Home, P.A. 21502			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not e	nter the mode of dyin	ng, such as cardiac or r	espiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	,		essive	Denne	o. tia		Onset and Death
	/Medical		resulting in death)	Due to (or as a	a consequence of):	233	Dem e	- Maria		3
	Examiner		Sequentially list conditions.	b	Alz	heimer's	s Dis	segue		A ('
	n =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of					
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c						
Ö,	e exe ian a urial-	Ex	resulting in death) Last	Due to (or as	a consequence of):					
8760,	ate b hysic the bi	dical		d	<del></del> -					
W.	artifica ing pl	Med	IF FEMALE:							
Box	leath certifi attending   I for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
	Physicien: The law requires that the death certificate has been signed by the attending this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4∏Pregnant at 9∏Unknown	time of death	5 ☐ Other (specify) _				
P.0	that the de ned by the a detached	Ph	Part II. Other significant conditions	contributing to death but	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	uires sign	d by	C.V. +	1. (Old				1 🗆 Yes	2 No 3□P	robably 4 Unknown
Ö	w requ	Completed	m ct	ed horosa	. A)./(	2 42 0 6	21 DO	24a. Was an	24b. Were a	utopsy findings available
3e	has ye 2	mp	0 31	7	autopsy perform	ed? death?	completion of cause of			
a	icien: Th certificate rector, pag		as the second has a disal				26. Place of Death			s 2 No
Ĭ,	ysicien: The l is certificate ha director, page	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ER/Outpat	ient 3□ DOA Ott	her: 4 X Nursing Home	THE AMERICAN TO SHARE		ocifu)
of	Phys r this ral dii	H :	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Inju			w injury occurred	iony
on	ding F h. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da)	y Year) Injur		ork? ]Yes 2 □ No			
Division	Atten deal ctor: y the	fica	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of Injury		street, factory, office	28		eet and Number or R	ural Route Number,
Di	after after Dire	Certification:	4  Homicide	building, et	с. (Ѕрөспу)			City or Town,	Siale)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier XXCertifying	Physician: To the best	of my knowledge, de	eath occurred at the t	ime, date and place, an	d due to the car	use(s) and manner a	s stated.
	ne Ho 7 24   ne Fu	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta		investigation, in my	opinion, death occurred			
	To the Tro the Tro the Comp	ž	29b. Signature and title of certifier			29c. Licen	se number		ld. Date signed (Mon.	
	3		)	( Jama	Uni Hi	J . D1	.4464		February	/, 2006
	43		30. Name and address of person wi			pe, Print)	-		3 1	04522
_			Sikander L.			Tarn Terr	ace, Frost	burg, M	aryland .	21532
		ate	31. Date filed (Month, Day, Year)		ar's Signature	11				
	Regist	rar	FEB 0	ZUUD Z	suce St.	poste				

# Evelyn L. Kendal Baltimore, Maryland 21215-0036

		•	For State Registrar	State of N	Maryland / [	Departmer <i>Certificat</i>			ental Hy	giene Reg. No:	106	06339
	Physici /Medic		1. Decedent's Name (First, Middle,  Evelyn Lucil						2. Date of De	aath Day	2000	3. Time of Death  4 9 45 PM
	Examir Funeral Director		4a. Facility Name (If not institution,  - Ahrhly-  5. Social Security Number  212–38–8554	Keedy n	MY SING! Age (In yrs. last/bir	rne	BOO!		8. Date of Bi (Month, Di Aug 4	th ay, Year)	Col	notation (State or Foreign intry)
	D >		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Lagation						10d. Inside City Limits
	Aaryla 1 shor	ъ		ngton		nsboro						1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number			10f. Zi	Code			10g. Citize	n of What Co	untry?
	th with	ai D	8507 Maplevil	le Road			2171	3		U.S	5.A.	
920	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or items 23s or 28s-f show other than "natural" or items 23s or 28s-f show event, the Medical Examination to the model.	by Funerai	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Deceder Armed Force 1  Yes 27 If Yes, Give Year or Date:	s? [] No	13. Was Dece If Yes, spe 1 \( \subseteq Yes		anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or Ne Rican, etc.)		Race - Amer Black, White Decify: Whi	, etc.
21215-0036	72 ho	Completed	15. Decedent's		16a.	. Decedent's Usu (Give kind of wo	ork done duri	n ng most of workir	1g	16b. Kind	of Business/I	ndustry
121	vithin ne. han "	mpje	Elementary/Secondary (0-12)	College (1-4c		Seamstre	,			Clot	thing M	/Ifa
d 2	should be filed within and Mental Hygiene. s marked other than " umatic event, I'm Me.		17. Father's Name (First, Middle, L	ast)		Sealis CT 6		. Mother's Name	(First, Middle			119.
lan	lid be lental rked c	To Be	Jacob Newton	Hawbaker				Mary Cat	herine	Harn	ish	
Maryland	pernit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic.		19a. Informant's Name/Relationsh			3		Number or Rura				
	of Health of Health item 27 i			Lvatore (gr								cyland 21783
Baltimore,	Pages 1 nent of Hi int: If iter iry or oth	1	20a. Method of Disposition  1 XBurial 2 Cremation	3 □Removal from Sta	te 20b. Place o	of Disposition (Na ery, crematory or	me of other place)	i	ate		tion - City or	
Him	perriit. Page Department of Impurtant: If any injury or once.	1	<ul> <li>4 □Donation 5 □ Other (Sp</li> <li>21. Signature of Funeral Service L</li> </ul>		Smiths	burg Cer		2-20				Maryland
Ba	permit. Page Department of Important: If any injury or		1) weela	A. Tu	ing	1331_1	Easter	n Blvd.	N. Hac	ersto	y Funei wn Mary	ral Home yland 21742
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o immediate Cause (Final disease or condition resulting in death)	a.	line.	8	ge or gying, s	uch as cardiac o	r respiratory a	arrest,		Interval Between Onset and Death
68760,	Medical Examiner  bhysician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Conto	as a consequence	of):	rt F	allux	E			157
O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 274.No 9 ☐ Unknown		2 Fetal death at time of death	n 3 ⊟Ectopic p 5 ⊟ Other (s				230	d. Date of deli Month	very Day Year
9	uires that signed b	by	Part II. Other significant condition	ns contributing to death	n but not resulting i	in the underlying	cause given i	n Part I.	1	tobacco use		the cause of death?
I Records,	The law requir ate has been si page 2 should	Completed							24a. Was auto perf 1  Yes		24b. Were au prior to death?	topsy findings available completion of cause of
Vital	Ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:				6. Place of Death				
of	ding Phys	tion: To	1 Yes 2 No  27. Manner of Death 1 Watural 5 Pending 2 Accident investig		njury 28b.		28c. Injury at Work?	Nursing Hon 2 2 □ No	ne 5 Res			elfy)
Division	al or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi	289. Place of	Injury - At home, fa etc. (Specity)	arm, street, facto	ry, office	2		(Street and I own, State)	Number of Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (		Physicien: To the be exeminer: On the basis and manner	s of examination ar							
	To the within To the comp	M	29b. Signature and title of certifier		$\supset$	29	c. License n				signed (Month	n, Day, Year)
			- On	und			05	2323	,	2/	1116	
5F	√-3 Sta Regist		30. Name and address of person of the control of th	aseem M	of death (Item 23a)  - //2 istrar's Signature	(Type, Print) -6 Opal	Cour	+ -H	agers	town	MD	21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			For State Registrar			nd / Depa		of Heal	th and N	Mental Hyg	iene	06	063	The state of the s
	Physici	an.	1. Decedent's Name (First, Middle		T					2. Date of Deat Feb. 1		O C Year	3. Time of I	
	/Medic		Sung	Man	Lee					reb. I	_		3:00p	р м
17.	Examir	er	4a. Facility Name (If not institution	_					tion of Death			ounty of Death		
	· · · · · · · · · · · · · · · · · · ·		12915 Travi	6. Sex	a a 7. Age (In yrs.	last hirthday)	If Under 1	tomac	nder 24 Hrs.	9 Date of Birth		ntgom	-	r Faraian
	Funeral Director		214-88-1421  Usual Residence of Decedent	1 <b>X</b> M 2 ☐ F	59	Yrs.		Days Ho		8. Date of Birth (Month, Day, 1 / 1 7 / 1		Kor	place (State or ntry) Cea	
	yland		10a. State 10b. County			ty, Town or Lo							10d. Inside Cit	
	Mar	tor	MD Mont	gomery	P	otoma	C						1 🗋 Yes	2X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28e-f show enty injury agents traumatic event, the Medical Evantion must be notified at once.	by Funeral Director	10e. Street and Number 12915 Travil	.lah Roa	d		10f. Zip C	0854		1	0g. Citizer	of What Cou USA	ntry?	
	dea dea	ner	11. Marital Status	Armed F	edent Ever in U	J.S. 13.	Was Decede	nt of Hispani Cuban, Me	c Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,		
36	or it	y Fu	1 Never Married 2 Mar	ried 1 ☐ Yes If Yes, G	2 XNo	1	1 ☐ Yes 25		ecity:	. ,	Sc		sian	
21215-0036	ural',	D D	3 Widowed 4 Divorced		Dates:	1 40 D								
<u>7</u>	"nati	Completed	15. Deceder (Specify only highe	it's Education st grade completed)	1	16a. Dece	dent's Usual kind of work DO NOT use	Occupation done during	most of work	ang	16b. Kind	of Business/In	dustry	
12	withir ane. then	d m	Elementary/Secondary (0-12)	College (	1-4or 5+)	1	anica				W_M	.A.T.	Α.	
р Б	Hygid ther ther ant,		12 17. Father's Name (First, Middle,	Last)		11.0011	4			e (First, Middle, I				
an	d be ed o	э Ве	Lee Won Sun					1		Ku Nam				
Maryland	mari mati	우	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	na Address (	Street and N	umber or Rui	al Route Number	. City or To	own, State, Zii	Code)	
S	Ith ar Ith ar 27 ie r trau		In Sun Lee/V				•			d. Poto	-			0854
ē,	Head the state of		20a. Method of Disposition		20b.	Place of Dispo cemetery, crei	sition (Name	of		Date	20c. Locat	tion - City or To	own, State	
Baltimore,	age in all		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	Gate c			2/15	/06 9	Silve	er Spr	ing,M	Гď
	artm ortar		21. Signatule Fineral Service	11										
ã	Ded Find Personal	Ш	> Xhelis NE	ulla		I	PHILII	P D.R	INALD	I FUNER	RALS	SERVIC	CE, P.A	0010
	-		23a. Part 1. Enter the disease, o	complications that	caused the dea	th. Do not ent	er the mode	of dying, suc	h as cardiac	or respiratory arr	est,	SULII	Approximate Interval Betw	9
	Physician		shock, or heart failure. List Immediate Cause (Final			tama 1	M 7 4. 4	£					Onset and D	leath
P-30	/Medical		disease or condition resulting in death)		ioblas		Multl	rorme						
	Examiner			1	,									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consec	quence of):			-					
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ó	be executed icien and burial-transit	Exa	resulting in death) Last		(or as a consec	quence of):			,					
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9	es that the death certifice igned by the attending ph be detached for use as th	Jed	IF FEMALE.											
Вох	death certifice e attending ph id for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant		atcome of pregn		Ectopic pred	inancy			23d	I. Date of deliv		
	e dea	by Physician/Med	in the past 12 months? 1 Yes 2 No		nant at time of		Other (spec	city)				Month	Day Y	'ear
P.0.	at the	Phy	9 Unknown							ac Bitte				
	The law requires that the ste has been signed by the page 2 should be detache		Part II. Other significant conditi	ontributing to d	leath but not res	sulting in the u	nderiying cau	ise given in F	an I.				he cause of de	
ord	w require been signature should b	ted								1 🗆 🕶	s 2 1	40 3 Pioi	bably 4 🗆 U	TKHOWH
ec	law las b	pje								24a. Was a autops	y	prior to co	opsy findings a empletion of ca	ıvaılabie ause of
<u> </u>		Completed								perform 1 ☐ Yes 2	med? Z∑No	death? 1 ☐ Yes	2 🗆 No	
Vital Records,	iclan: Th certificate rector, pag	Be	25. Was case referred to medica examiner?					~	Place of Deat	th (Check only on	Θ)			
of	ding Physician: h. After this certifical funeral director.	2	1 Yes 2 No			ER/Outpatier			Nursing Ho	ome 5 Reside			(y)	
Ē	ing F	on	27. Manner of Death 1   Natural 5   Pendin	19	of injury oth, Day Year)	28b. Time of Injury		Work?	0 DV	28d. Describe ho	w injury o	ccurred		
Division	Attending r death. sctor: After by the funer	Certification:	2 Accident investi	not be	a of laiver. At h	town town of	M	1 Tes	2 _ No	28f. Location (St	root and A	humbas as Due	al Davita Alumah	<b></b>
Ξ	or A after Direct in by	it.	4 Homicide determ	ined build	e of Injury - At h ling, etc. <i>(Speci</i>	ify)	eet, ractory,	опісе		City or Town		variber or Aur	ai noule ivuill	J <del>0</del> 7,
كبيت	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying	ng Physician: To th	a hast of my kn	owledge death	h occurred at	the time de	to and place	and due to the a	21150/5/ 55	d manners as a	stated	
	Hos 24 hc Fun stely	edical	(Check only one)	Examiner: On the b	e best of my kn basis of examination of stated.	ation and/or in	vestigation, i	ny opinion	, death occur	red at the time, d	ate and pla	ace, and due t	o the cause(s)	,
	o the	Me	29b. Signature and the of certifie				29c.	License num	ber	2	9d. Date s	igned (Month,	Day, Year)	
	0,50		> CHA	1	~ m	7	D.	35635				.14,20		
7	U		30. Name and address of erson	who completed car	se of death (Ita	m 23a) (Type	Print)							
			Joseph Kap					ilin	Dr Ol	ney,Md	2001	2.2		
<b>18</b>	Sta	te	31. Date filed (Month, Day, Year,	32.4	egistrar's Sign	ature	ash 8		~ <u> </u>	THE A PLACE	400	14		
	Regist	_	FFB 1	5 2006	reason.	15 19	Aller Alle Street							

			For State Registrar		of Marylan		artment o			nd Mental I	Reg. No	A D		050	and a second
н	Physicia	an	1. Decedent's Name (First, Middle							2. Date o Month	Da	ž, 20	Year O.6		of Death
	/Medic	al	Ralph John Litt  4a. Facility Name (If not institution		mber)		4b. City, To	own. or l	Location of	Febru		. County o		3:15	<b>A</b> M
	Examin	er	5509 Old Nation	-			,,		rick			Fred			
	Funeral Director		5. Social Security Number 215–20–8923	6. Sex 1 <b>⊠</b> M 2 ☐ F	7. Age (In yrs. <b>78</b>	last birthday) Yrs.	If Under 1 Months C	Year Days	If Under 2 Hours	Min (Month	Birth Day, Year 15, 1	)	Cou	place (State intry) yland	e or Foreign
	and W	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
	Maryl -f sho	ξ	Maryland Frede	rick	I	rederi	ck							1 □ Y€	es 2 🛣 No
	h the	irec	10e. Street and Number				10f. Zip C	ode			10g. Ci	itizen of Wi	nat Cou	intry?	
	23e c	aiD	5509 Old Nation	al Pike				1702			Uni		Stat		
336	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene do they than "netural", or items 23e or 28e-f show do ther than "netural", or items 23e or 28e-f show event. The Medical Examir at must be notified at	by Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed F	2 No		Was Deceder If Yes, specify 1 ☐ Yes 2 <b>2</b>	_	spanic Orig n, Mexican Specify:	jin? (Specify Yes o , Puerto Rican, etc	r No- )		, White,		
215-0036	72 hou	Completed	15. Decedent	's Education	)	16a. Dece	dent's Usual (	Occupa done di	tion	of working	16b. H	Kind of Bus	iness/Ir	ndustry	
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ณ	filed w Hygier other ti	S	12 17. Father's Name (First, Middle,	l act)		Self	Employ		18 Mothe	r's Name (First, Mi		rpent			
anc	d be findal H	) Be	Ralph John Litt						Erma	Tobery	adio, ivialdoi	77 00/1/2/1/0	,		
Maryland	s 1 and 2 should be in thealth and Mental litem 27 is marked oothar traumatic eve	္ရ	19a. Informant's Name/Relations			19b. Maili	ng Address (S			r or Rural Route N	umber, City	or Town, S	tate, Zi	p Code)	
	1 and 2 Health ar Iem 27 is		Nancy Little/ V	life		5509	Old Na	atio	nal l	Pike, Fre	deric	k, MD	217	702	
ë.	es 1 a of Hei of Hei r othe		20a. Method of Disposition	2 Domewal from		Place of Dispo	matory or other	er place	3)	Date		_ocation - C			
altimore,	Page ment ant: It		1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (S		Fre					2/16/2001					
Balt	permit. Pages Department of t Important: If ite any injury or of once.		21. Signature of Funeral Service	my		16	521 Opc	ossu	ımtowi	Stauffer Pike, F	reder			21702	
-	Fnysician /Medical		23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Chra		bstr	uctive			oardiac or respirato		ise		Approxim Interval B Onset an	Between
8760,	The law requires that the death certificate be executed  The las been signed by the attending physicien and  agge 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence of the consequence)										
P.O. Box 6	that the death certifics led by the attending pl detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live	utcome of pregnation to the pregnation of the pr	al death 3[	⊒Ectopic preg ☐ Other (spec				- 1	23d. Date Mon		very Day	Year
rds, P.	quires that in signed by uld be deta	by	Part II. Dther significant condition	ons contributing to	death but not res	sulting in the u	inderlying cau	use give	en in Part I.		Did tobacco 1 <b>X</b> Yes 2	_	bute to		of death?
Il Records,		Completed									Was an autopsy performed? ′es 2 ⊠N	pr de	rior to co eath?	topsy finding ompletion o	gs available if cause of
Viital	sician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital				Othe	ar:	of Death (Check of					
Division of \	Attending Physician: ir death. ector: After this certificaby the funeral director, i	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date		ER/Outpatie 28b. Time o Injury		c. Injury Work	4 🗆 140		Residence ribe how inj			ify)	
Divisi	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At h ding, etc. (Speci	ome, farm, st fy)	reet, factory,	office			ion (Street a r Town, Sta		r or Rui	ral Route N	lumber,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	th occurred at evestigation, in	t the tim	e, date an pinion, dea	d place, and due to th occurred at the t	ime, date ar	nd place, a	nd due	to the cause	
	To the vithin 2 complet	Σ	29b. Signature and title of certifie	'Ome	eva	M		$\wedge$	36	121	- 1	$I^*$ .	_ 1	1, Day, Year 200 (	
\	51111		James Am	erena	god3	m 23a) (Type,	field	#10	14 F	iederick	Md	2170	01		
	Sta Regist		31. Date filed (Month, Day, Year)	7 2006 32.	Polistrar's Sign.	ature	foot	•							

			For Stata Registrar		State of	Marylar				ealth a			Reg. No.	UU	6	063	42
	/sicia	n	1. Decedent's Name (First, Middle Nellye E. Mc									2. Date of Dea Month FER	Day		Year	3. Time	_
	ledica amine		4a. Facility Name (If not institution Anne Arundel M	n, give str	eet and numb			4b. City		Location o	olis	FLO	-	County	of Death	Arunde	
Fune Direc			5. Social Security Number 212-16-6116 Usual Residence of Decedent	6. Sex 1 ☐ I	M 2⊠F 7	Age (In yrs. 86	last birthday) Yrs.	If Under	Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Feb. 8	y, Year)	20	Cou	place (State ntry) yland	or Foreign
Maryland	led at		10a. State 10b. County Maryland Anne	Arun	del	10c. Ci	ty, Town or Lo	ocation	An	napol	lis					10d. Inside	City Limits s 2 ☐ No
with the	Denvi	Direc	10e. Street and Number 17 East Street					10f. Z	ip Code	21401			-	izen of W	Vhat Cou	ntry?	
d 21215-0036 flied within 72 hours after death with the Maryland Hygiene. ther then "naturel; or teme 23a or 28a-f ehow	Examiner mus	by Fur	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	bei	. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? <b>Ç</b> No	-	Was Dec If Yes, sp	- 1	spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	-		k, White,	can Indian, etc. ite	• • • • • • • • • • • • • • • • • • • •
21215-0 within 72 ho iene. rthen "natur	Lie Madical	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)			or 5+)		dent's Us kind of w DO NOT mema.	rork done d use retired	ation during mos	it of work	ing	16b. Ki		n Ho		
aryland should be filed and Mental Hyg	atic event,	To Be C	17. Father's Name (First, Middle, Nelson Sonderg	,								e (First, Middle, ade Ingv			Θ)		
and 2 sho salth and in 27 is mu	r traum		19a. Informant's Name/Relations Sharon Topper/					_				Riva,				Code)	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or Iteme 23a or 28a-1 ehow	eny injury or othe once.		20a. Method of Disposition  1 Burial 2XX remation 4 Donation 5 Other (S	pecity)	Λ	ate	Place of Dispo cemetery, creaters. timore	matory or Crei	other plac nator	1	2/18/	2006 hn M. T	Balt	timo	re, l	own, State Maryla al Hon	
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8760, cate be executed xi	ine burial-transit	dicai Examiner															
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cords, P. w requires that been signed by	9	ò	Part II. Other significant condition			th but not re		nderlying	cause give	en in Part I		23e. Did to			ibute to t	he cause of	death? ]Unknown
	page 2	Completed										24a. Was autop perfo 1 Yes		p	rior to co leath?	opsy finding impletion of 2 \( \text{No} \)	
	100	0	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No		spital:	atient 2	ER/Outpatier	nt 3 🗆 🗈	OA Othe			me 5□Resid		6 □Othe	ar (Speci	6v)	
On O	= I'	ation: T	27. Manner of D ath 1 Natural 5 □ Pendir 2 □ Accident Investi		28a. Date of		28b. Time o Injury		28c. Injury Work			28d. Describe				,,	
- 20 -		Certification:	3 Suicide 6 Could 4 Homicide determ		28e. Place o building	Injury - At h , etc. <i>(Speci</i>	nome, farm, sti fy)	reet, facto	ry, office			28f. Location (5 City or Tov			er or Rur	al Route Nu	mber,
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To th withir To th	dwoo	ž	29b. Signature and title of certifie	r ,					9c. License				29d. Dat	te signed	l (Month,	Day, Year)	
			30. Name and address of puson	who com	MD pleted cause	of death (Ite	m 23a) (Type,	Print)	257	53	<u> </u>		FE!	3 1	4, 2	006	
			Mohit Nica	7 2	3601	veter	rans H	wy	, Su	te 2	04,	Miller	svil	le,	MD	2110	8
Re	Stat gistra	-	31. Date filed (Month, Day, Yea)	5 200		istrar's Sign	ature	Good									

DHMH 17 Rev 1/2001

			For Amend#10e, f 2/15, State Per FH AACO HE		d / Depa <i>Cer</i>	artment of <i>tificate of</i>	Health and I Death		iene	6	0631	į, į
1	<b>第</b> 日		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Year	3. Time of [	)eath
	Physicia /Medic		Andre Marc Merette					Februar		2006	5:30	$\mathbb{A}^{M}$
1	Examin		4a. Facility Name (If not institution, give sa	treet and number)		4b. City, Town,	or Location of Death	1	4c. County	of Death		
	hope of	gró <u>.</u>	Genesis Eldercare -			Annap		1011	Anne			
W. or	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 71	ast birthday) Yrs.	If Under 1 Yea Months Day:		No Wanth, Day	Year 9 34	9. Birthp Court	lace (State or	Foreign
184	Director		Usual Residence of Decedent						, =	Cana	iua	
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City	/ Limits
	Man a-f sh	to	Maryland Anne Arun	de1		Anna	polis				1 🗌 Yes	2 <u>M</u> No
	h the	Director	10e. Street and Number 930 As		0	10f. Zip Code		1	0g. Citizen of	What Cour	itry?	
	th wil	ai D	930 Astern Way # 61			2140	1		-Canad	a Ca	nada	
	within 72 hours after death with the Maryland ene. thsn "returel", or items 23a or 28a-f show the Medical Evanither must be notified at	Funerai	11. Marital Status	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	S. 13. V	Was Decedent of f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ ck, White,		
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🌠 No If Yes, Give		1 ☐ Yes 2 🔀 N	o Specify:		Specif	y: Wh:	ite	
21215-0036	hour turel	q pe	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's Educ	Year or Dates:	16a Decer	dent's Usual Occ	unation		16b. Kind of B			
7	in 72	Completed	(Specify only highest grade	completed)	(Give		e during most of wor		TOD. PRING OF D	43111633/111	adatry	
72	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4	(	Computer	'S		Informa	tion	Tech	
b	illec I Hyg other	Be C	17. Father's Name (First, Middle, Last)			op u e u e		ne (First, Middle, I			10011	
lar	uld be Aenta rked tic ev	ToB	Joseph Merette				Marie C	ote				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23s or 28s-1 show any figury or other traumatic event, the Medical Examinat must be notified at Once.	0 1	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ng Address (Stree	et and Number or Ru	ıral Route Number	, City or Town	State, Zip	Code)	
Σ	and 2 salth n 27 i		Nancy Merette / Ex-				reek Driv		olis,			.403
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re		lace of Dispo emetery, cren	sition (Name of natory or other p	lace)	Date	20c. Location	- City or To	wn, State	
Ē	Pag ment ent: l		4 □ Donation 5 □ Other (Specify)			Cremato	ry 2/14	/2006	Baltimo	re, l	Mary lar	ıd
Balt	Depart Import Import In Inj		21. Signature of Juneral Service License	е			ress of Facility Jo					
_	₹0 = a d		" The holy	0			of Glouce			olis		
په ښه			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the deat e cause on each line.	h. Do not ent	er the mode of d	ying, such as cardiad	or respiratory arr	est,		Approximate Interval Betw Onset and D	reen
Y	Physician		Immediate Cause (Final disease or condition resulting in death)	Colon	Car	1 CeV					ton	
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						YEGE	-
	. F	_	Sequentially list conditions, b.	Cus to (or as a consec-	uahou idh						,	
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	000 10 (37 23 3 50 100 1	asines cry							
	al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
8760,	cate be executed physician and the burial-transit	dical E	d									
68	ificate g phy as the	edic										
Вох	andin use	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Testania programas				te of delive	•	
	deati	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		]Ectopic pregnar ] Other (s <i>pecify)</i>			M	onth	Day Y	ear
P.0	that the death certific ed by the attending p detached for use as	Physician/Me	9 Unknown									
	Se Co	by F	Part II. Other significant conditions conf	1 100	ulting in the u	nderlying cause (	given in Part I.		bacco use con			
Vital Records,	w requir been si should	ted	<u>Ulcevanve</u>	101110				1 U Y	es 2 No	3 🗌 Prob	bably 4 🔲 U	nknown
ec	elawr hasbe ge 2sh	pie						24a. Was a autops	SV	prior to co	psy findings a mpletion of ca	
<u> </u>	G -T	Completed						perform 1 ☐ Yes		death? 1 ☐ Yes	2D] No	
/ita	riclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			10		ath Check only or	7e)			
	Physiclen: this certific ral director,	٩	TIL Tes 20 No	1	ER/Outpatien	it 3 DOA		lome 5 Reside			у)	
n C	ing After une	ion:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	luryat lork? □Yes 2□No	28d. Describe h	ow injury occur	rrea		
Division of	Attending ir death. ector; After by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Ptace of Injury - At he	ome farm str			28f. Location (S	treet and Num	her or Rura	i Route Numi	ner.
Š	after Direction by	ertif	4 Homicide determined	building, etc. (Specif		cot, ractory, one	•	City or Tow				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wiedge, death	n occurred at the	time, date and place	e, and due to the o	ause(s) and m	anner as s	tated.	
	• Ho • Fu • Fu letely	edicai	(Check only 2 Medical Examin one)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death occu	urred at the time, d	late and place,	and due t	the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. Lice	nse number	Z	9d. Date signe	ed (Month,	Day, Year)	
			· VXX	MN		00	051201	1	e6No	14/3	, 200	8
			30. Name and address of person who cor	mpleted cause of death (Item	n 23a) (Type,	Print)	1 1-	1		1		^-
			Keyld & Knop.		resig	ate P	040 \$ 3	30 A	Mapo	115,	MD 21	49
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	double.			€,,,			

			1 - For State Registrar	State of N	Maryland	•	artmen rtificate			and M		Reg. No		0634	FOTChesis in
	Physici		Decedent's Name (First, Middle, Last     Alma Elaine Miller	,							2. Date of De Month Febru		1, 2006	3. Time of Do	eath M
	/Medic Examin		4a. Facility Name (If not institution, give		or)		4b. City,		Location o	of Death		40	. County of De	ath	
			12008 Emmettdale Lar 5. Social Security Number 6. Se		Age (In yrs. la	st hirthday)	If Under		Shaft If Under:	24 Hrs.	8 Date of Bir		llegany	irthplace (State or F	Foreign
	Funeral Director		220-40-1367	_M 2 F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 14-Apr-	1915	Ma	ryland	-Or <del>o</del> igir
	and W		Usual Residence of Decedent  10a, State 10b, County		10c. City,	Town or Lo	cation							10d. Inside City	Limits
	72 hours after death with the Maryland neturel', or items 23a or 28a-1 ehow disal Exactination by neithed at	tor	Maryland Allegan	y	Frostb									1 ☐ Yes 2	
	th the	Funeral Director	10e. Street and Number 12008 Em	mettdale La	ne, SW		10f. Zip	Code				10g. Ci	itizen of What C	Country?	
	23a	rai	P. O. Box				215					U.S.			
	er deg	une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force 1 Tyes 2	s?	i. 13. )	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Wh		
920	el, or	by F	3 ⊠Widowed 4 □ Divorced	If Yes, Give (			1 🗆 Yes	2 No	Specify:				Specify: Whi	ite	
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation furing mos	t of worki	ng	16b. k	(ind of Busines	s/Industry	
121	be filed within 72 hours after death with the Marylan stal Hygiene. ad other than "neturel", or items 23a or 28a-f ehow other than "neturel", or items 23a or 28a-f ehow event, the Madical Examination of the control o	Completed by	Elementary/Secondary (0-12)	College (1-4o	or 5+)	owner.	,		,			chil	dren's clo	thing stor	
pu	be filed value tal Hygie d other l	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maidei	n Sumame)		
Maryland 21215-0036	should be and Mental marked c	To	Clifton Walter Skidm					10:	Prisci			0.	- 0	7. 0. 11	
Mar	d 2 th a trac		19a. Informant's Name/Relationship (7) Royal C. Miller	ype, Print) SON		9294 C					Market		or Town, State, irginia	22844	
re,	is 1 and of Health Item 27 other tr		20a. Method of Disposition		20b. Pla	ace of Dispo metery, crer	sition (Nan	ne of ther place			ate		ocation - City o		·
<u>im</u>	Page ment c ant: If ury or	1 7	1 ☐ Burial 2 🗖 Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Removal from Star )	le l	berland				13-F	eb-2006 (	umb	erland Ma	aryland	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licenter	Durst	1		2. Name an Durst F				ost Ave.,	Frost	burg, MD	21532	
			23a. Part1. Enter the disease, or compositions, or heart failure. List only of	lications that caus one cause on each	sed the death.	Do not ent	er the mod				,	rrest,		Approximate Interval Betwe Onset and Dea	
	Physician /Medical	25	Immediate Cause (Final disease or condition resulting in death)  a										5 year		
	Examiner			Due to (or a	as a conse ju	ence or):									
	ק אַ	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or a	as a conseque	ence of):									
_	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):				-					
8760,	rate be executed obysician and the burial-transit	lical E		d											
9	death certificate be executed e attending physician and nd for use as the burial-transit	Medi	IF FEMALE:												
Вох	eath ce attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?		ne of pregnan 2  Fetal of at time of dea	death 3[	Ectopic pr						23d. Date of d Month	elivery Day Yea	ar
0	that the dended by the a	hysic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown		atii 3C	10the (3p	ochy)							
Records, P	<ul> <li>requires that the been signed by th should be detache</li> </ul>	by	Part II. Other significant conditions co	intributing to death	n but not resul	lting in the u	nderlying c	ause give	en in Part I.		23e. Did t			to the cause of dea Probably 4 Tunk	
eco	law as b	ompieted									24a. Was	DSV	prior to	autopsy findings ava	ailable ise of
a B	Th ate pag	O									1 ☐ Yes	ormed? 2 □ No	death? 1 ☐ Ye	es 2 No	
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1  Inpa	atient 2 🗆 E	R/Outpatier	nt 3 DC	Othe	200		n <i>(Check only o</i> me 5. Affesi		6 □Other (Sp	ecify)	
ion of	ding h. After fune	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of It (Month, I		28b. Time o Injury		8c. Injury Work	at		28d. Describe			. ,,	
Division	al or Attendi after death. I Director: A d in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place of	Injury - At hor etc. (Specify)	ne, farm, str	eet, factory	, office			28f. Location ( City or To	Street a wn, Stat	nd Number or F e)	Rural Route Numbe	ır,
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 ☐ Certifying Phyone) 2 ☐ Medical Example 1		s of examination										
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/_					number				ate signed (Mor	1 7	
)	3		1/ily/2					N3(	اماام	0			01	113106	
	nds		30. Name and address of person who o	Par.	1200	14.	Print) D. 9	24.	Sertz.	UZ	R. Cin	unl	ser Gun	13 06   1111 21 <u>:</u>	502
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regi	strar's Signati	ure		,	- /		_/			/	
	Registi	rar	FEB 1 4 2006	132	- J	600	Charles and the								

DHMH 17 Rev 1/2001

			1 - For State Registrar		State of M	laryland		artmen rtificate			and M	ental Hy	gien	2001	7	063	
	Physici /Medio		Decedent's Name (First, M.  Rose M. McK									2. Date of De Month	eath Di	ŽČ	ear O	3. Time of 1	Death M
	Examir		4a. Facility Name (If not instituted as Social Security Number	tion, give s	HOSP	ge (In yrs. la	et hirthday)	4b. City,	imk	Location of	anc	8. Date of Bi		Alle	90	<u>Ny</u>	Foreign
238	Funeral Director		213-24-6699 Usual Residence of Decedent	1 🗆	M 20 F	79	Yrs.	Months	Days	Hours	Min.	Month, Di	ay, Year			place (Suite or ntry) yland	reoreign
	Maryland f show	20.	10a. State 10b. Cou			10c. City,	Town or Lo	cation							1	10d. Inside Cit	
	with the Marylar a or 28a-f show	Director	10e. Street and Number	Allegan 906 Na	ional Highw			10f. Zip	Code				10g. C	itizen of Wha	at Cour	ntry?	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or itama 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 1 Nover Married 2 1 Nover Married 2 1 Nover Married 2 1 Nover Married 2 1 Nover Married 2 Nover Married	Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	? No	1	Was Deced f Yes, spec 1 ☐ Yes		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or Ne Rican, etc.)	. U.S	14. Race - Black, Specify:	White,	etc.	
21215-0036	within 72 hours ane. than "natural", na Medical Exa	Completed	(Specify only high Elementary/Secondary (0-1	- T		5+)	life.	kind of woi DO NOT us	k done d	uring most	of workii	ng		(ind of Busir	Vhita ness/In	dustry	
and 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I'm Mi	Be	17. Father's Name (First, Midd	tle, Last)			attend	dant				(First, Middle		taurant n Sumame)			_
Maryland	2 should be and Mental Is marked o	2	Michael Arnor 19a. Informant's Name/Relati		oe, Print)				,		r <b>Fabb</b> ir or Rura	ri   Route Numb	er, City	or Town, Sta	ate, Zip	Code)	
	es 1 and of Health fitam 27 r other tr		Donald J. McK 20a. Method of Disposition		husbar	20b. Pla	19906 ace <b>Highw</b> metery; crer	Nation		a)		tburg ate		Marylar .ocation - Ci		21532 own, State	2
Baltimore,	t. Partmer		1 Burial 2 □ Cremati 4 □ Donation 5 □ Othe  21. Signature of Funeral Serv	(Specify)		,	stburg M		l Park			Feb-2006	Frost	burg	Mar	yland	
Ba	Dermi Depe Impo		23a. Paper. Enter the disease	12.5	Wurt	A	Do set set					rost Ave		stburg, N	AD 2		
	Physician /Medical Examiner	er	Mock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ist only on	Due to (or a:	line. 35 / VE s a conseque	ence of):					LAR		CCID	8N	Approximate Interval Betw Onset and D	veen Death
68760,	To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	l°.	Due to (or as	s a conseque	ence of):										
P.O. Box (	that the death certifica ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3□	Ectopic pr Other (sp						23d. Date of Month		•	'ear
	w requires that been signed b should be dete	by	Part II. Other significant cond	ditions con	tributing to death	but not resul	iting in the u	OC/	ause give	n in Part I.	AL		tobacco Yes 2			he cause of de	
Vital Records,	: The taw re cate has be ; page 2 sho	Completed	INPA		TON							24a. Was auto perfe 1 \( \text{Yes} \)		prio	re auto or to co oth? Yes	psy findings a impletion of ca 22 No	available ause of
f Vita	ding Physician: The h. After this certificate hi funeral director, page	To Be	25. Was case referred to med examiner?  1 Yes 2 No		ospital:	ient 2 🗆 E	R/Outpatier	nt 3 DO	A Othe	r.		(Check only ne 5□Res		6 Other	(Specif	y)	
ion of	nding Physith. Ith. :: After this s funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Per 2 ☐ Accident inv	nding estigation	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	at ? ′es 2 ☐ /		8d. Describe	how inju	iry occurred			
Division	il or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of Ir building, e	njury - At hor tc. (Specify)	ne, farm, str	eet, factory	, office		2	8f. Location ( City or To			or Rura	al Route Numb	ber,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certi (Check only 2 Medi	lying Phys cal Examin	ician: To the besi ier: On the basis and manner s	of examination	rledge, deatl on and/or in	occurred vestigation,	at the tim in my op	e, date an inion, deat	d place, a th occurre	nd due to the	cause(s	s) and mann d place, and	er as s	tated. the cause(s)	
	To th Withir Comp	Me	29b. Signature and title of cer	tifier	7	1	7	290	License	number	04			ate signed (I			
	nus		30. Name and address of pers	1	mpfeted cause of	death (Item	23a) (Type,	Print)				vay L	aVa	le m	1)	2150	2
	Sta Registr		31. Date filed (Month, Day, Ye	ar)		rar's Signatu	ire	Cook		• • • • • • • • • • • • • • • • • • • •	J		·				
100				# 10 Y	II W	Albert Co.	- 47	3400									

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health and N Certificate of Death	Reg No.	006 06316
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Deeth Month Day	3. Time of Death
/Medical	EDUARDO MASTRANGELO	FEB. 3,	2006 5:30 PM
Examiner	4a Fecility Name (If not institution, give street and number) 4b. City, Town, or L		County of Death
	DEVLIN MANOR NURSING HOME  5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.		ALLEGANY
Funeral Director	5. Social Security Number 218-60-2182  6. Sex 1 M 2 F 7. Age (In yrs. lest birthday) 1 M onths 1 Days 1 Days 1 Min.  1 Under 1 Year 1 Under 24 Hrs. 4 Months 1 Days 4 Hours 4 Min.	8. Date of Birth (Month, Day, Yeer) FEB• 3, 19	9. Birthplace (State or Foreign Country)  11 TALY
dand w	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Many art sh	MD ALLEGANY CUMBERLAND		Yos 2 □ No
or 28	10e. Street and Number 10f. Zip Code		zen of What Country?
th will the state of the state	160 BEDFORD STREET 21502	U.	.S.A.
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ▼ Married  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S.  Armed Forces?  1 □ Yes ★ No  If Yes, Give  Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp  If Yes, specify Cuban, Mexican, Puerto  1 □ Yes ★ No  1 □ Yes ★ No Specify:		14. Race - American Indian, Black, White, etc.  Specify: WHITE
5-0 72 hc	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired)	ina 16b. Kir	nd of Business/Industry
To en en en en en en en en en en en en en	Elementary/Secondary (0-12) College (1-4or 5+)	1	7 TT DO7 D
led w her that the cor	12 STATION MASTER		AILROAD
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If them 27 is merked other than "natural, or any Injury or other traumatic event, the Madical Example.  To Be Completed by F		e (First, Middle, Maiden : NA CASTELLAI	
lar 2 sho and I s me	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	al Route Number, City or	r Town, Stete, Zip Code)
and and health m 27	GIOVANNI MASTRANGELO / SON 10210 TOWN CREEK ROAD,		
ges 1 If itel or ot	20a. Method of Disposition  1 ☒ Burlal 2 ☐ Cremation 3 ☐ Removal from State		cation - City or Town, State
tim tmen tant:		2/06/2006 FI	LINTSTONE, MD
Bal Permi Depar Impor	21. Signature of Funeral Service Cicenses  22. Name and Address of Facility UPCHURCH FUNERAL I 202 GREENE STREET	, CUMBERLANI	D, MD 21502
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final		Offset and Beath
Examiner	disease or condition resulting in death)  a. Colonium Arty MSC	aft	years
i i	Due to (or as a consequence of):		0
68760, ifficate be executed g physician and as the burial-transit ledical Examiner	Sequentially list conditions, Due to (or as e consequence of):		<u>                                     </u>
68760, ificate be exa physician a as the burial-ledical Ex	Sequentially list conditions, frain, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events the initiated events are consequence of):		
set of cate to the	that initiated events Due to (or as a consequence of):		
_ = O a	d		
Bc eath e			
the d	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	4	use contribute to the ceuse of death?
Is, P.O. Box es that the death cer igned by the ettendin be deteched for use by Physician/N	Advana Dementia	1 ☐ Yes 20	XNo 3 Probably 4 Unknown
requir		24a. Was an autop: performed?	sy 24b. Were autopsy findings available prior to completion of cause of death?
I B I he l		1 ☐ Yes 24	No 1□Yes 2□No
of Vital Rec nysician: The law is certificate has to I director, page 2 s	examiner?	h (Check only one)	
O.E O.	1 ☐ Yes 1 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Nursing Ho	me 5 Residence 6	
ing P kiter t unera	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work?	28d. Describe how injury	/ occurred
ISIC Itendi Jeath tor: A the f	2 Accident investigation 3 Suicide 6 Could not be	28f Location /Ctract	Allumbar or Dural Davida Humbar
or Al or Al or Al or Al in by	4 ☐ Homicide  determined  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, State)	d Number or Rural Route Number,
Division of V  To the Hospital or Attending Physic within 24 hours efter death.  To the Funeral Director: After this ca  Completely filled in by the funeral director  Medical Certification: To	29a. Certifier  (Check only one)  1  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, to 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, to 2  Medical Examiner: And manner stated.	and due to the cause(s) a ed at the time, date and	and manner as stated. place, and due to the cause(s)
o the omple omple	29b. Signature and title of certifier 29c. License number	29d. Date	e signed (Month, Day, Yeer)
F 3 F 8	D21244	ŧ .	17/2006
pel	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		11/2006
,	Jesus Too. MD 4 Brondway, Frostburg MI	2/532	
State	31. Date filed (Month, Day, Year) 32. Beoferar's Signature		
Registrar	FEB 0 7 2006 Seem & Sporte		

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of <i>rtificate o</i>			giene Reg. No. 006	06347
F4		S.	Decedent's Name (First, Middle,	Last)				2. Date of Dea	ith	3. Time of Death
	Physici /Medic		Connie LaRue	Martin				Februar	y 19, 2006	03:30 A M
Y	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town	n, or Location of De		4c. County of Dea	
			13817 Ideal Cir	cle		Hagers	town		Washing	on
-	Funeral			6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Ye	ar   If Under 24 H		h . 9. Biri	hplace (State or Foreign
	Director		220-40-0745	1 ☐ M 2 🖾 F	67 Yrs.	Moritis Day	ys Hours M	Jan. 11		y land
	D 3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	acation				404 1-14-05-11-11
	aho	ō	,							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the A	ect	Maryland Washin  10e. Street and Number	gton	Hagersto	10f. Zip Code			10 000	
	with a or	Funeral Director	13817 Ideal Cir	010					10g. Citizen of What Co	ountry?
	eath	era	13017 Tuear CTT	12. Was Decedent	Ever in II S 13	2174		/Specify Ves or No.	USA 14. Race - Ame	rican Indian
<b>'</b>	r Iten	Fun	1 Never Married 2 Marrie	Armed Forces?		If Yes, specify C	uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, Whit	
93	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠N	No Specify:		Specify:	
21215-0036	within 72 hours after death with the Maryland of the "returns", or liems 23a or 28a-1 show the Madical Examiner must be notified at	Completed	15. Decedent's	Education	16a. Dece	dent's Usual Occ	cupation		16b. Kind of Business/	ite Industry
21	thin 7	pje	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	life.	NOT use reti	ne during most of w ired)	vorking		·
21	or th	Con	12	3		stered N	urse		Hospital	
nd	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, L.	ast)			18. Mother's N	lame (First, Middle,	Maiden Sumame)	
<u>Ia</u>	Ment Ment arked	0	David Frederic	k Cline			Beulah	Catherin	ne Bowers	
Maryland	and and is my		19a. Informant's Name/Relationshi	р (Туре, Print)	19b. Maili	ng Address (Stre			r, City or Town, State, 2	Zip Code)
≥.	and ealth n 27 ner tr	1	Robert M. Marti	n (Husband)				agerstown,	, Maryland	21742
altimore,	1 ter		20a. Method of Disposition 1    Burial 2   Cremation :	3 □ Removal from State	20b. Place of Dispo	sition (Name of matory or other p	olace)	Date	20c. Location - City or	Town, State
Ĕ	Pag ment ant: I ury o		4 Donation 5 Other (Spe		Greenlawn	Mem. Pa	ark Feb.	22. 2006	Williamspor	t, Maryland
ä	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygien. Important: If time 27 is marked other than "natural; or Itema 23a or 28a-f show any injury or other traumatic event, it a Madical Examinar must be multified at once.		21. Signature - Funeral Service Li	en se	022	Name and Add	dress of Facility	22, 2000	with Conses	cheague St.
<u> </u>	80 = 20		Duty C	M	Wi	lliamsp	ort, Mary	/land 217	795	cheague ST.
п	.48		23a. Part. Enter the disease, or of shock, or heart failure. List of	omplications that caused	the death. Do not ent	er the mode of d	lying, such as card	ac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1		1 274 1	1 51	105/1		Onset and Death
1 100	/Medical		resulting in death)	Due to/(or as:	a consequence of):	CA 184	COCLE	2003/3		15 mo~743
	Examiner		Coguantially list conditions	b						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	з сопвециелсе ођ.					
	cuter	Examiner	that initiated events	c						
Ö,	e exe	Ä	resulting in death) Last	Due to (or as	a consequence of);					
8760,	icate be executed physician and s the burial-transit	dica		d						
9	ng ph		IF FEMALE:							
Box	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnar	ncv		23d. Date of deli	,
	e dea	Sici	in the past 12 months?	4☐Pregnant at 9☐Unknown	time of death 5	Other (specify)			Month	Day Year
0.	that the de led by the a detached f	Phy	9 Unknown							
ΰ	es ti igne be c	þ	Part II. Other significant condition	s contributing to death bu	it not resulting in the u	nderlying cause o	given in Part I.		pacco use contribute to	
Records,	w require been si should b	ted						1 🗆 Ye	es 2⊠No 3∏Pro	obably 4 Unknown
ပိ	has by	be						24a. Was a autops	n 24b. Were au	topsy findings available ompletion of cause of
		Completed						perform	ned2/   death?	
Vita	E = 5	Be (	25. Was case referred to medical examiner?				26. Place of D	eath (Check only on		
	d: 5	္	1 Yes 2 No		nt 2 ER/Outpatien	t 3 DOA	Other: 4 🗌 Nursing	Home 5 Reside	ence 6 Other (Spec	uty)
ב	After t	Ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Inj	ury at ork?		w injury occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 ☐ Accident investiga	tion			☐Yes 2☐No			
	or Atten after deatl Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, farm, str . (Specify)	eet, factory, office	е	28f. Location (Sti City or Town	reet and Number or Ru n, State)	ral Route Number,
	ospital or A hours after uneral Dire ly filled in b	ပိ								
	T 4 T 0	edical	Check only 2 Medical E	Physician: To the best of caminer: On the basis of	examination and/or inv	occurred at the	time, date and place	ce, and due to the ca	tuse(s) and manner as	stated.
	vithin 2 To the complet		5/10/	and manner sta	ted.					
	2 × 0 0	-	29b. Signature and title of certifier	th C	,		nse number		9d. Date signed (Month	
,			Millian 4	Const	D, MQ	D	005139	5	02/20/	2006
2/1			30. Name and address of person wi	no completed cause of de	eath (Item 23a) (Type,	Print)				21742
X-1-	2		31. Date filed (Month, Day, Year)	no completed cause of de	//////////////////////////////////////	CAR CAMI	pus Ko, S	U/7 = 107,	HAGEISTO	an, MO.
100	Stat	ie ar	FEB 2 0	02. 110gistia	rs Signature	,				

			1- State of Maryland / Dep Registrer Ce	artment of Health and M rtificate of Death		ene 0 0 6	06348
		H	Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physici /Medic		Curtis Lee MILLER		Februar	$y \stackrel{\text{Day}}{10}, 200$	6 10:22 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	ath
			Washington County Hospital	Hagerstown		Washingt	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign Country)
ı.	Director		215-78-0706 46 Usual Residence of Decedent		June 19	1959 M	aryland
	/land		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mar	į	Maryland Washington Hage	erstown			1 ☐ Yes 2√ No
	th the	ě	10e. Street and Number	10f. Zip Code	10	g. Citizen of What C	Country?
	23a	a L	1512 Howell Road	21740		USA	
	teme teme	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spellf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
020	rs afte	by F	1 Never Married 2 Married 1	1 ☐ Yes 🎢 No Specify:		Specify:	T T
3	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or items 23a or 28a-f show int, the Madical Examinar must be notified a		15. Decedent's Education 16a. Dece	ident's Usual Occupation	1	6b. Kind of Busines	White s/Industry
2	hin 72	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	s kind of work done during most of work DO NOT use retired)	ing		
7	filed with Hygiene. other ther	S		iter Support		_Credit (	Card
2	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	laiden Surname)	
2	2 should be i and Mental I is marked or eumatic eve	မ	Earl McArthur Miller	Dolores			
	12 sh h and 7 is m			ing Address (Street and Number or Rura			
3)	s 1 and 2 should be filed within 72 hours after death with the Marylan fer Health and Mental Hygiene a few or Items 28a or 28a-f show fem 21 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Marical Examinar must be natified at		Earl M. Miller - Father 374  20a. Method of Disposition 20b. Place of Dispo	S. Cannon Avenue,		Oc. Location - City of	
2	ages int of t: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory`or other place)			
allimo	permit. Pages Department of the Importent: If its end injury or of once.		Rest liav	en Cemetery 2/16/2. Name and Address of Facility Mir			, Maryland
۵	Departing Department of the poores.			.15 E. Wilson Blvd.		neral Home stown, Md.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	hysician '	b .	fmmediate Cause (Final	keroscheratiz cardinas			Onset and Death
	/Medical		disease or condition resulting in death)  a. HYPERTY HIT Duelto (or as a consequence of):	CHATTOWN)	(UW) 130	va	
ľ	Examiner		Sequentially list conditions, b.				
	ed ist	ulne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	icate be executed physicien and s the burial-transit	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
0/00,	sicier sucier	dical					
0	tificat ig phy as th	-					
5	death certif e attending nd for use a	an/N	IF FEMALE: 23b. Was decedent pregnant 1	☐Ectopic pregnancy		23d. Date of de	,
5	res that the death certifigned by the attending be detached for use a	Physician/M		Other (specify)		Month	Day Year
	hat th d by detact		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause awas in Part I	23a Did tobs	acco use contribute	to the cause of death?
'n	The law requires that the te has been signed by th bage 2 should be detache	d by	Takin and against the second and the	and onlying cause given at 1 at 1.	1 🗆 Yes	✓	Probably 4 □Unknown
cords,	w require been sig should b	ete			24a. Was an		outopey findings evoluble
ב ב	he law e hes ige 2 s	Completed			autopsy	ed? prior to death?	autopsy findings available completion of cause of
2	en: T	0	25. Was case referred to medical	26. Place of Death	-		s 2 No
-	ysici is cer direc	To B	examiner? 1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 XER/Outpatie	Othor	710-3-11	nce 6 □Other (Sp	ecify)
5	ng Ph fter th neral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe how	w injury occurred	
VISION	lendii eath. or: A the fu	cati	2 Accident investigation	M 1 Yes 2 No			
2	or At litter d Direct in by	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	pours cours and filled		29a Certifier 1 Certifying Physician: To the best of my knowledge deal	th recounse at the fives, state and place.	and due to the car	under and wassers	ne etatad
	To the Hospital or Attending Physicien: The within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only one)  2. Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurr	ed at the time, da	te and place, and du	e to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mor	nth, Day, Year)
			ywi. 2th	OCME	Fe	ebruary 11	1, 2006
_	-6		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 111 PEnn Street, l	Baltimore	e. Marvla	nd 21201
J	Sta	te	31. Date filed (Month, Day, Year) - 32. Registrar's Signature			,	
ą	Registr		FEB 1 6 2006 Fram B.	took			

			1- State of Maryland /		artment <i>tificate</i>			nd Me		jiene eg. No. 0	6	063	
1	Physici	an	1. Decedent's Name (First, Middle, Last)  Louis Leonard Meier, Jr.						2 Date of Dea Month Februar		2006	3. Time o	of Death  D M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)		•		Location of			4c. County	of Death		
	Funeral		5132 Baltan Road           5. Social Security Number         6. Sex         7. Age (In yrs. last b)	irthday)	If Under 1		If Under 2	4 Hrs.	8. Date of Birth (Month, Day		9. Birth	omery	or Foreign
=0	Director		561-54-2055 <sup>1⊠M 2□F</sup> 87	Yrs.	Months	Days	Hours	Min.	Oct. 1	2, 1918	Cal		.a
	/łand		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tox	wn or Lo	cation							10d. Inside (	City Limits
	e Man	Director	Maryland Montgomery	Beth ———	esda								2 2 No
	with th		10e. Street and Number		10f. Zip (				1	0g. Citizen of \		intry?	
	neath me 23	Funeral	5132 Baltan Road  11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decede	816 ent of Hi	ispanic Orig	jin? (Spec	ify Yes or No-	14. Rac		ican Indian,	
036	2 should be filed within 72 hours after death with the Maryland and Mentle Hygiene. Is marked other than "neturel; or Items 23a or 28a-f ehow sumatic event, the Medical Exami, ar must be notified at	by	1 ☐ Never Married 2 ☑ Marned 1 ☐ Never Married 2 ☑ Marned 1 ☐ Never Married 2 ☑ Marned 1 ☐ Yes, Give Year or Dates: 1941-7	1	fYes, specr I□Yes 2	fy Cuba	n, Mexican, Specify:	Puerto F	lican, etc.)		ck, White, y: Whi		
Maryland 21215-0036	"netur	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	(Give	lent's Usual kind of work	k done d	during most	of workin	g	16b. Kind of B	usiness/Ir	ndustry	
121	within iene. rthan	omp	Elementary/Secondary (0·12) College (1·4or 5+) 5 +		oo NOT üse ral Ca		" in/Att	torne	ev	U.S. N	avv/	Legal	
b	al Hyg	0	17. Father's Name (First, Middle, Last)			Į.				Maiden Suman			
ylaı	iit. Pages 1 and 2 should be artment of Health and Menta priant: If Item 27 Is marked injury or other traumatic ev is.	To	Louis Leonard Meier, Sr.						e Gabr				
Z Z	id 2 st lth and 27 is n traun	1 27								r, City or Town, aryland			
re,	of Hea		20a. Method of Disposition 20b. Place	of Dispos		e of		Da	ate	20c. Location -			
Baltimore,	Page ment cant: If		1 Purial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	-				May 200		Arlingt	on,	Virgin	ia
Ball	permit. Page Department of Important: If eny injury of		21. Signature of Funeral Service Licensee	F2 50	ancis O Uni	ver:	sity I	ins E Blvd,	Tuneral W, Si	Home I lver Sp	nc ring	, MD 2	20901
19 18(3)			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode	of dyin	g, such as o	ardiac or	respiratory arr	est,		Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Myocardial Inf		ion								
	Examiner		Due to (or as a consequence Alzheimer's Di	,	e								
	p ii	iner	Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of).									
_	le be executed /sicien and e burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence	∍ of):			-				$\rightarrow$		
8760	cate be executed hysicien and the burial-transi	dicai E	d										
9	ertifica ling phy e as th	Medi	IF FEMALE:										
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		Ectopic pre						te of deliv Inth	ery Day	Year
Ö.	at the de by the stached	hysi	1 Yes 2 No 9 Unknown		,								
rds, P	ires than signed a be de	by	Part II. Other significant conditions contributing to death but not resulting  Hypothyroid	in the un	nderlying ca	use give	en in Part I.			bacco use conl es 2 ☐ No		the cause of bably 4 🔀	
Division of Vital Records,	o - o	Completed							24a. Was a autops perform	med?	Were auto prior to co death? 1 🔲 Yes	opsy findings ompletion of	available cause of
<u>i</u>	Physician: Th this certificate ral director, pe	Bec	25. Was case referred to medical examiner?					of Death	Check only or			20.00	
<u>o</u>	Physic this co	<u>و</u>	1 ☐ Yes 2 💆 No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient Time of			4 🔲 14Ur	-		ence 6 Oth		fy)	
on	nding th. : After e funer	ation		Injury	M	C. Injury Work	k? Yes 2□N		od. Describe in	ow injury occur	60		
Divis	To the Hospitel or Attending Physician: which 24 hours after deals as a feet this certification the Funeral Director. After this certification place in the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	arm, stre	eet, factory,	office		2	8f. Location (S City or Tow	treet and Numb n, State)	er or Rur	al Route Nur	nber.
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowled on the basis of examination a and manner stated.	je, death nd/or inv	occurred a restigation,	it the tim	ne, date and pinion, deat	place, a	nd due to the c d at the time, d	ause(s) and ma late and place,	inner as s and due l	stated. to the cause(	s)
	To the To the comp	Me	29b. Signature and title of certifier				number 12832			9d. Date signe			
5	10+1		#MM//V	-		LID				Februar	у 14	, 2000	
7			30. Name and access of person who completed cause of death (Item 23a) Gerald Denton, M.D. 8901 Wiscon	,,	,	ie.	Bethe	sda.N	4D 2089	9			
	Sta	te			sell								
	Registr	ar	FEB 15 2006 A	A CONTRACTOR OF THE PARTY OF TH									

		•	For State Registrar	State of Marylan	•	nent of H			giene	006	06350
80			Decedent's Name (First, Middle, Last)					2. Date of Dea		Vans	3. Time of Death
	Physicia		William ,	Denver	]	Nave		Month	03	(X°ar	18510 M
)	/Medic Examin		4a. Facility Name (If not institution, give si	HOSPITO	11	Cum	Location of Death	10		Ounty of Death	Mu
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Cou	, ,
10	Director	-	Usual Residence of Decedent	M 2LIF 79	TIS.			07/19/1	926	Penns	sylvania
	and		10a. State 10b. County	10c. Ci	ty, Town or Location	n					10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show rmust be notified at	ō	MD Allega	n 17	LaVale					1	1 ☐ Yes 2 ☐ No
	the 28a	Director	10e. Street and Number	II y		of, Zip Code	· · · · · · · · · · · · · · · · · · ·		10g. Citize	en of What Cou	ntry?
	3e or	<u></u>	913 Weires Av	OTHO		21	1502			USA	
	ne 2:	Funerai		2. Was Decedent Ever in U	.S. 13. Was		spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	- 14	. Race - Ameri	
2-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or Iteme 23e or 28e-f show event, the Medical Examiner must be notified at event, the Medical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ⊠Yes 2 □ No 194  If Yes, Give Year or Dates: 194	1-1	s, specify Cubai ∕es 2∭ No	n, Mexican, Puerto Specify:	Hican, etc.)		Black, White, Specify: W1	eic. nite
ž	2 hou	Completed	15. Decedent's Educ	ation	16a. Decedent's	s Usual Occupa	ition	uin n	16b. Kin	d of Business/In	
7	hin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	or work done d IOT use retired,	luring most of wor )	King			
7	d with	E	8		Shift	Superv	isor		T	ire and	Rubber
and	e filed Il Hygi other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden S	Gumame)	
ā		To E	Cromwell	Nave			Montra	S	y1va1	nia	Howsare
a	s 1 and 2 should f Health and Men itém 27 is marke other treumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Ad	dress (Street a	und Number or Ru	ral Route Numbe	er, City or	Town, State, Zij	Code)
Ma.	and 2 ealth a n 27 ls		Wanda L. Nave /				enue, LaV	/ale, Ma	ry1a1	nd 215	02
9	of He item		20a. Method of Disposition		Place of Disposition cemetery, cremator	n (Name of ry or other place	e)	Date	20c. Loc	ation - City or T	own, State
Ĕ	Pages ment of sant: If it		1XXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	MD	Vet. Cem	e Rock	cy Gap 02	2/06/200	6	Flintst	one, MD
dairimor	permit. Par Departmen Important: any injury once.	Ì	21. Signature of Funeral Service License	0 7	22. Na	me and Addres	s of Facility Ada	ams Fami	ly F	uneral	Home, P.A.
ñ	P O F E	Ì	Kabut C.	edam	404	Decatui	Street	Cumber	land	, Maryl	and 21502
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea	th. Do not enter th	e mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CAC	nt.	Ordina.	· ·				Onset and Death
10	/Medical		resulting in death)	Due to (or as a consec	quence of):	1					
	Examiner			cone	novesu	en a	cide	24			
ď,	an 18	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
	uted	Examiner	Cause (Disease or injury that initiated events								
o Î	an an rial-tr	EX	resulting in death) Last	Due to (or as a consec	quence of):						
9/9	death certificate be executed e attending physician and of for use as the bural-transit	dicai	<b>U</b> d								
õ	ntifica ng ph as th	Med	IS SEMALE.								
XOD	leath certific attending p i for use as	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		opic pregnancy			23	3d. Date of deliv Month	ery Day Year
	dea ded fo	sicia	in the past 12 months?	4 Pregnant at time of o		ner (specify)				MONUI	Day Teal
r Ö	at the	Å.	9 Unknown								
Ś	requires that the de: een signed by the a hould be detached t	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the under	lying cause give	en in Part I.		1	,	the cause of death?
Vital Record	w requir been si shauld	ted						10	Yes 2	No 3 □ Pro	bably 4 Unknown
ပ္ထ	> 40	pie						24a. Was		24b. Were auto	opsy findings available ompletion of cause of
Ĭ	The tee h	Completed							rmed? 2/2 No	death? 1 ☐ Yes	
<u> </u>	vysician: Th	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	one)		
	× 5 5	2	1 ☐ Yes A No	ospital: Inpatient 2	ER/Outpatient 3	DOA Othe	er: 4□ Nursing H	ome 5□Resi	dence 6	Other (Speci	fy)
0	ng Phy ter thi neral		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe	how injury	occurred	
<u>0</u>	auth. or: Af	atic	2 Accident investigation		!		Yes 2 □ No				
Division of	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fy)	factory, office		28f. Location ( City or To		Number or Aur	al Route Number,
	itel o irs af ral Di led ir										
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my kn er: On the basis of examin- and manner stated.	owledge, death occ ation and/or investi	curred at the ting igation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and (	and manner as a place, and due to	stated. to the cause(s)
	To the withing To the To the To the Comp	Me	29b. Signature and the of certifier	20-41		29c. License				signed (Month	
	5/1VA		> Steven /	Schun		DO	01821	0		2/3/0	6
	JIOA		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Prin				i iA	10 0	1500
			Dr. Steven SMH	h. MD am	notas.	NIVA	CHAIN	ærland	A K	JID d	1 ( ) ( ) ( ) ( )
	nds		U. SICVIII SITI	111	21011	1111	CUIT				
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6 200	32. Registrar's Sign	ature Ana	DINC	COLL				

			1 - For State Registrar		artment of Health and M rtificate of Death	ental Hygier	TECOU dull's						
2	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death						
	/Medic	al	Haja Lamrana No 4a. Facility Name (If not institution, give street a	oah	4b. City, Town, or Location of Death	FEBRUARY	18 2006 7:45 p M						
	Examin	er	St. Mary's Hospital	no namb <del>a</del> ry	Leonardtown		St. Mary's						
*	~ Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Birthplace (State or Foreign						
	Director		Unknown 1 M 28	77 Yrs.	Monto Sayo	12-6-192							
	land land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits						
	Mary a-f sh	tor	MD St. Mary's	Hollywo	od		1 ☐ Yes 2 ② No						
	or 284	Olrec	10e. Street and Number		10f. Zip Code		Citizen of What Country? Republic						
	s 23a	rail	25065 Peregrine Way		20636		Sierra Leone  14. Race - American Indian,						
36	be filed within 72 hours after death with the Maryland nital Hygiene. so other than "natural", or Items 23a or 28a-f show event, Ite Madical Examinar must be notified.	by Funeral Director	1 Never Married 2 Married 1 H	s Decedent Ever in U.S. 13. led Forces? 13. les 2. No es, Give ar or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black  Specify: Black						
21215-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade comp		dent's Usual Occupation kind of work done during most of working	16b.	Kind of Business/Industry						
21	withIn 7 ene. than "r	Completed		lege (1-4or 5+)	DO NOT use retired)								
	e filed wat Hygler other the		17. Father's Name (First, Middle, Last)		Homemaker  18 Mother's Name	(First, Middle, Maid	Own Home						
Maryland	fental h fental h rked of	o Be	Alaji Suliman Jallo	nh		mata Jal							
ary	s 1 and 2 should I f Health and Meni item 27 Is marker other traumatic	2	19a. Informant's Name/Relationship (Type, Prin		ng Address (Street and Number or Rura								
	1 and 2 Health a tem 27 ls		Susan Annie Dexter/Da	aughter 2506	5 Peregrine Way, H	ollywood,	MD 20636						
Baltimore,	of He of He If item or oth	1	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Remova	20b. Place of Disponentery, cre	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State						
Ë	Pag tment tant:		4 □ Donation 5 □ Other (Specify)	Charles		Charles and the Control of the Contr	onardtown, Maryland						
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		21. Signature of Funeral Service Licensee  Edward N. Brinsfield,	Jr. M00052 2	2. Name and Address of Facility Bri 2955 Hollywood Roa	d, Leonar	dtown, MD 20650						
4. 3.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  mmediate Cause (Final										
	Physician /Medical		disease or condition a	Stroke.									
	Examiner			Oue to (or as a consequence of):	remiation.								
		ner	Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying	Due to (or as a consequence of).									
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events c.										
8760,	cate be executed physicien and the burial-transit		Tesuring in dealin) Lasc	Due to (or as a consequence of):									
387	physics the t	dlcal	d.										
.O. Box (	at the death certifii by the attending I tached for use as	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year						
Δ.	₽ <b>₽</b> ₩	by Ph	Part II. Other significant conditions contribution		underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?						
rds	w requires been sign should be		Hypertensi	ON'		1 ☐ Yes	2 No 3 Probably 4 Unknown						
Vital Records,	taw re as be 2 sho	Completed	J.			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
E B		Соп				performed							
Vita	Physician: This certifice	Be	25. Was case referred to medical examiner?	/	Other	(Check only one)							
of	Phye r this ral dii	.: To	1 162 5 ENO	. Date of Injury 28b. Time	nt 3 DOA 4 Nursing Hol	me 5 Residence 28d. Describe how in	6 ☐Other (Specify)						
ion	Attending F r death. ector: After by the funer	atlor	Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No								
Division	l or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not be determined 28e	. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)						
Ω	Hospital or 24 hours afte Funerat Dire tely filled in I		200 Cartifice 1 F Cartifying Physician	To the best of my knowledge doe	th conversed at the time data and also	and due to the sauce	v(a) and manner as stated						
-	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examiner: Or	n the basis of examination and/or in difference stated.	th occurred at the time, date and place, anvestigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)						
7	To the I within 2 To the I complet	Ž	29b. Signature and title of cartifier	^	29c. License number		Date signed (Month, Dey, Year)						
			1 NAME	M.D.	D60888		02/21/06						
			DR. RAKHI KRISHNAN		, Print) HOLLYWOOD MD 2063	36							
Œ.	Sta Regist		FEB 2 2 2005	32. Degistrar's Signature	no de								

LAMARNA NOAH

		1 _ State	ryland / Department of Health and N Certificate of Death	/	(1116 11635)
		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Beauti	Reg. N  2. Date of Death  Month A D	3. Time of Death
Physic /Med	lical	MOSELL	E OLI VER  4b. City, Town, or Location of Death	2	c. County of Death
Exam	iner	4a. Facility Name (If not institution, give street and number)	H LAUREL		PRINCE GEORGE
Funera		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea.	9. Birthplace (State or Foreign Country)
Directo		Usual Residence of Decedent	00	10.101	/// Joseph Challenge
partilling is, Interpretable A. I. A. I. 2000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show environs: other treametic event, the Middled Examinating missible invitibled at more	to	10a. State 10b County  RINCE TENTS	10c. City, Town or Location  BELTSVILLE #1	102	10d. Inside City Limits 1 ☐ Yes 2 No
or 286	Funeral Director	10e. Street and Number	11 11 10f. Zip Code 2/1 14/1	10g. C	itizen of What Country?
death w ms 23e	eral	11. Marital Status 12. Was Decedent 8	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,
s after o	y Fun	1 Never Married 2 Married I Yes 2 N	If Yes, specify Cuban, Mexican, Puèric lo 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc.  Specify: BIDII
2 hours	ted by	15. Decedent's Education	16a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
vithin 7 ne.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Give kind of work done during most of work life. DO NOT use retired)	ang -	HIME
filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide	in Sumame)
should be nd Mental marked umetic ev	ToB	SAMUEL OLIVER	. Moz	ELLE 1	BIOUNT
Mar d 2 sho lth and lth and 27 ls m treum		19a. Informant's Name/Relationship (Type, Print)  DATOLOGA OLIVEO	19b. Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
es 1 and of Health litem 27		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disposition (Name of gemetery, crematory or other place)	Date 20c.	Location - City 1 Town, State
Definition Pages Department of I mportent: If its my injury or or or or or or or or or or or or or		' 4 ☐ Donation 5 ☐ Other (Specify)	KIVERDALE CREY	7/3/06 X	IVerdale MD.
permit. Departn Importe eny inju		21. Signature of Funeral Service Licensee	22 Name and Address of Facility  HAMBERS FU	NERAL HO	ME RIVERDALE MD
		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on wich lin	the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Physiciar /Medica	_	Immediate Cause (Final disease or condition resulting in death)	terio Scleratic Cardi	o Vasuelar	Desvere Over 1480
Examine	_		a consequence of):		,
be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ā CunSeydenice vi).		
execut execut in and ial-trar	Examiner	that initiated events c.	a consequence of):		
ficate be executed physician and stee transit	dical	d			
ath certific titending p	n/Me	IF FEMALE: 23b. Was decedent pregnant			23d. Date of delivery
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?  1  Yes 2 No 9  Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy time of death 5 ☐ Other (specify)		Month Day Year
that the ned by a detac	by Phy	Part II. Other significant conditions contributing to death b	ut not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
equire equire sen sig		Sende	Sementia	1 ☐ Yes	2 No 3 Probably 4 Unknown
necords, he law requires e has been signi tge 2 should be	ompleted			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
VICION: The icion: The contificate rector, pag	O	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 ☐ ↑	
Physici Physici rthis cer	To B	examiner?  1  Yes 2 No Hospital: 1 Inpatie		ome 5 Residence	
ding P th. After I	tlon:	27. Manner of Death  1 Natural  2 Accident  28a. Date of Inju (Month, Da)	ry 28b. Time of 28c. Injury at Work?  M 1 Tyes 2 No	28d. Describe how inj	ury occurred
To the Hospitel or Attending Physicien: The taw within 24 hours after death.  To the Funerel Director: Atter this certificate has completely filled in by the funeral director, page 2	Certification;	2 □ Cuicide 6 □ Could not be	ury - At home, farm, street, factory, office c. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
spitel o		29a, Certifier 1 Certifying Physician: To the best	of my knowledge, death occurred at the time, date and place	and due to the cause	s) and manner as stated.
in 24 h in 24 h ihe Fur pletely	edical		examination and/or investigation, in my opinion, death occuted.	rred at the time, date a	nd place, and due to the cause(s)
with To t	Σ	29b. Signature and title of certifier	29c. License number	29d. D	late signed (Month, Day, Year)
1		30. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print)	1120	· · · · · · · · · · · · · · · · · · ·
-		SYED SAND 1437	Bath (116m 23a) (1ypa, Print) Back Singular	St 208 L	HUREL MD 20708
S Regis	State Strar	31. Date filed (Month, Day, Year) FEB 15 2006	ar's Signature		

Tina Marie Pezzanite Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-01281 Unpend item 27 Mary and 55-5-10 (Ment of Health and Mental Hygiene crn Certificate of Death Reg. No: 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** February 20. 7:45 Tina Marie Pezzanite 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Memorial Hospital Cumberland If Under 1 Year If Under 24 Hrs. 5. Sociaf Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F Yrs. 234-23-3889 June 25,1968 Director Virginia Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 X Yes 2 ☐ No Director Mineral Ridgeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Wabash Street 26753 USA Funerai Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Efementary/Secondary (0-12) Coftege (1-4or 5+) 12 Department Supervisor Department Store 18. Mother's Name (First, Middle, Màiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h James Andrew DiMarino, Sr. Delora L. Ellis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Joseph L. Pezzanite. Husband P.O. Box 1023 Ridgeley, WV 26753 other ' 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of F-Important: if ite any injury or ot. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Duling Cemetery 2006 Keyser, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Smith Funeral Home Draw o. 85 S. Main Street 26726 Keyser, WV Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac arrhythmia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? 1D Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ☐ ER/Outpatient 3 ☐ DOA After this tuneral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending To the Hospital or Attandinwithin 24 hours after death.
To the Funeral Director: All completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 21, 2006 f death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06354 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) February 22, 2006 Physician 12:30 AM Norma Vivian Pickett /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Collington Episcopal Lifecare Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Washington, DC 8. Date of Birth Feb. Pay Year 923 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sex **Funeral** Months Davs Hours 1 □ M 2 ☑ F 83 577-28-8614 Yrs. Director Usuel Residence of Decedent with the Merylend 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Upper Marlboro % Yes 2□No Maryland Prince George's r 28a-f Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number thems 23a or ð 20774 302 Herrington Drive by Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: filed within 72 hours efter 1 Never Married 2 Married Specify: White th end Mentel Hygiene. 7 is marked other than "naturel", or i traumatic event, the Medical Exami Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ₹ No Specify: 31 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) C & P Telephone, Co. Manager 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Peges 1 and 2 should be Sarah Eleanor Milburn William Lee Godfrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302 Herrington Dr. Upper Marlboro, MD Jack M. Pickett, Jr. / Son Health em 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of Himportant: if its any injury or ot once. Arlington National Cem. 1 D∕Burial 2 ☐ Cremation 3 ☐ Removal from State 3-6-06 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses/ 6512 NW Crain Hwy. Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Examine The law requires that the death certificate be executed buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been signed rector, page 2 should be de 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 20 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No Medical Certification: To this within 24 hours efter death.

To the Funerel Director; After this completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Menne of Deeth 28e. Date of Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stelled. one) To the 29d. Date signed (Month, Dey, Year) 29b. Signature end title of ca

20

State

Registrar

31. Dete filed (Month, Day, Year)

000

32. Registrer's Signature

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

OWEKUL

MAR 0 2 2006

A312 Bowle M

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mai		artment e rtificate				gien Reg. N	2006	06356	
旗	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Steven L. Pollak  2. Date of Death Month Day Year February 7, 2006 11:02 II										
	Examir		4a. Facility Name (If not institution, give 119 Lazy Hollow				sburg	h		c. County of Dea Montgome	ath		
	Funeral Director		5. Social Security Number 6. Se 065-38-8018 1	x 7. Age			f Under 24 Hrs Hours Min.				9. Birthplace (State or Foreign Country) New York City		
Baltimore, Maryland 21215-0036	e Maryland 3a-f show	ctor	10a. State 10b. County  Maryland Montgome		10c. City, Town or Lo Gaithers	_						10d. Inside City Limits X☐ Yes 2☐ No	
	th with th	al Director	10e. Street and Number 119 Lazy Hollow Dr	ive		10f. Zip Co	ode 0878			itizen of What C	country?		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show many ny ny or other traumatic event, I're Modical Examinar must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 MDivorced	12. Was Decedent Ev Armed Forcas? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deceder If Yes, specify	Cuban, I	anic Origin? (S Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Am Black, Wh Specify:		
	d within 72 h jiene. r than "natu rr e Medical	To Be Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	(Give		done duri retired)	ing most of wo. istrato		16b.	s/Industry			
	ould be filed Mental Hyg larked othe latic event,		17. Father's Name (First, Middle, Last) Walter Pollak					Stella	me (First, Middle, a Oster				
	t and 2 sh Health and Im 27 Is m ther traum		19a. Informant's Name/Relationship (T)  David E. Pollak -		19b. Mailie 1050	North	Tay1	or Stre	para Route Number 20	02,	Arlingt	ton, Virgini 22201	
	It. Pages rtment of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens		сетеtету, crei Garden of	Remem	or piace) bran		/2006	Cla:		, Maryland	
eg E	Dep tmp any		Forold C.	Stattler					al Direc e, Rockv		n, Inc. e, Maryl	land 20852	
10 m	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Heart Disease  Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
Hecords, P.O. Box 68760,	death certificate be executed e attending physicien and of for use as the burial-transit	dical Examiner	Sequentially list conditions, If any least is trimmodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Hypertension  Due to (or as a consequence of):									T. Itala	
	death certifi e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregi Other (speci					23d. Date of de Month	Blivery Day Year	
	requires that the de neen signed by the a hould be detached t	þ	Part II. Other significant conditions co	23e. Did tobacco use contribute to 1 Types 2 No 3 Pe							o the cause of death?		
	The law ate has b page 2 s	Certification: To Be Completed									prior to death?	utopsy findings available completion of cause of s 2 \square No	
<u> </u>	sician: Th certificate rector, pag		25. Was case referred to medical examiner?	Hospital:					th Check only o				
JIVISION OF	Attending Physician: If death. ector: After this certific by the funeral director.		1  Yes 2 No  27. Manner of Death  1 Natural 5  Pending 2  Accident investigation	2 ER/Outpatier  28b. Time of Injury		Injury at Work?	4 ☐ Nursing F		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
	i i i i i		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Example one)	sician: To the best of ner: On the basis of ea and manner state	xamination and/or in	occurred at the occurred of th	the time, my opini	date and place on, death occu	, and due to the orred at the time,	ause(: date ar	s) and manner a nd place, and du	s stated. e to the cause(s)	
ł	15	Σ	29b. Signature and title of certifier  D31800							29d. Date signed (Month, Day, Year) February 8, 2006			
	*		30. Name and address of person who corrected A. Pets	rick, M. D.	. 6001 Mor	Print) ntrose	Road	, # 21	l, Rockv	i11	e, Mary	land 20852	
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 5 201	32? Registrar's	s Signature	well							

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				Type or State or	P <mark>rint in E</mark> f Marylan						-		_	ole.	06357	
			for State Registrar			Cei	rtificate	of l	Death			Rag. No	o.	7	0,000.	
П			Decedent's Name (First, Middle, Last)											3. Time of Death		
	Physici /Medic		Mar	ilyn Ma	e Potte	r					FEB	20	,		2:35 A M	
	Examin		4a. Facility Name (If not institution, given				4b. City, Town, or Location of Death						c. County o			
			CIVISTA MEDICAL	CENTER			LAPLATA						CHARLES			
	Funeral		,	Sex 1 □ M 25 <b>7</b> F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Septemb	irth ay, Year	1000	9. Birthi	place (State or Foreign ntry)	
	Director		217 12 3337	-X.	0	3 Yrs.					Septemb	er 24	,1924	Colo	rado	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation								10d. Inside City Limits	
	Mary f she	ō	Maryland St. Mar	v's	Le	xingto	n Pari	k							1 ☐ Yes 2 No	
	288 288	Directo	10e. Street and Number	J -			10f. Zip					10g. C	itizen of W	hat Cou	ntry?	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exartime rout be notified at	Die	21895 Pegg Road,	Apt. 12	8		20	653					USA			
	deatl	Funerai	11. Marital Status	dent Ever in U	Ever in U.S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue					ecify Yes or N	10-	14. Race - American Indian, Black, White, etc.				
٥	or Ite	Fu	1 Never Married 2 Married	1 TYes	1 □Yes 2 K⊓No			1 ☐ Yes 2 No Specify:								
3	ural',	d by	3X Widowed 4 □ Divorced	rear or Dates:										Specify: White		
7	"nati	Completed	15. Decedent's E (Specify only highest gr	ducation a <i>de completed)</i>		16a. Dece	dent's Usua kind of wor DO NOT us	k done o	ation during mos	st of work	ing	16b. l	Kind of Bus	siness/Ir	ndustry	
7	withir ane. than	d L	Elementary/Secondary (0-12)	College (1	-4or 5+)	Telephone Operator						Telephone Company		pany		
Maryland 21215-0036	Hygie ther ont,	e Co	17. Father's Name (First, Middle, Las	·)		тетер	none	орег		er's Name	e (First, Middle					
a	d be ental ked o	To B	Donald Miller						Go1	die I	LOY					
$\mathbf{\bar{z}}$	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-1 show aumatic event, the Madical Examination ust be indifficit at	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street			al Route Num	ber, City	or Town, S	State, Zij	o Code)	
E	nd 2 alth a 27 is		Sharon Lea Gardiner	Daughter	•	28003	Cedar V	View	Court,	, Mech	anicsvi]	Lle, N	Maryla:	nd 20	659	
Baltimore,	s 1 a f He ftem othe		20a. Method of Disposition  20b. Place of Disposition (Name of Date Competent or other place)  20c. Location - City or Town, State									own, State				
	Page ient c nt: ff ry or		1 Specific 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Charles Memorial Gardens 23, 2006  Leonardtown, Maryland													
<u>=</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic es		21. Signalure of Funeral Service Lice	nsee	(	) 22 M	2. Name and	d Addre	ss of Facili	ity France	oral Hom	n D	٨			
m	20E 20		Thechael Teven	Had	nu >	P	.O. Box	270	, Leon	ardto	eral Hom wn, Mary	lánd	20650			
1													Interval Between			
	Physician		Immediate Cause (Final disease or condition	my E	y Edema								Onset and Death			
	/Medical Examiner		resulting in death)	Due to	Due to (or as a consequence of):											
	Examine		Sequentially list conditions,	b. Phasada  Due to (or as a consequence of):												
	bed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Jue to	Hypaalbuminemia											
	be executed ician and burial-transif	хап	that initiated events resulting in death) Last	c. Due to	Due to (or as a consequence of):											
60,		-m		. ાંગ	fec te	d So	xcial	L	Jow	nd						
68/	icate phys s the	dic		d	1											
Box	that the death certificate ed by the attending physi detached for use as the	/W	IF FEMALE: 23b. Was decedent pregnant		come of pregna								23d. Date	a of deliv	rery	
ň	death a atte	iciai	in the past 12 months?  1 Ves 2 Felo 4 Pregnant at time of death 5 Other (specify)							Month Day Year						
Ö.	t the by the	by Physician/Medic	9 □ Unknown	9 Unkn	own											
ທົ	res tha		Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	inderlying ca	ause giv	en in Part	l.			-/		the cause of death?	
ä	w require been sig should b	ed									1	]Yes 2	No.	3 Pro	bably 4 □Unknown	
Records,	aw re	Completed									24a. Wa	s an	24b. W	lere auto	opsy findings available empletion of cause of	
ř	The lay	E O									per 1 Yes	formed? 2 8 N	d	eath?	2₩No	
Vita	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical 26. Place of Death (Check only one)													
Division of V	Physic this ce al dire	Tol	1 ☐ Yes 2 No			ER/Outpatie			4 🗀 🖂		me 5 Re				fy)	
	ng P	on:	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date (Mon	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?									∌d		
Sio	death death ctor: / the f	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or F								or Pun	n I Pouto Number				
$\leq$	or At after of Direct in by	ırtifi	4 Homicide determined	Zoe. Flace	ng, etc. (Special		reet, ractory	, onice			City or To			ii oi nui	ar noble Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying P	hysician: To the	best of my knr	owledge, deat	h occurred	at the tir	ne, date a	nd place	and due to the	е сацѕа/	s) and mar	nner as	stated.	
	24 h	edicai	(Check only 2 Madical Exa	miner: On the b	asis of examina ner stated.	ation and/or in	ivestigation,	in my o	pinion, dea	ath occur	red at the time	e, date ar	nd place, a	nd due f	to the cause(s)	
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier				29c	. Licens	e number			29d. D	ate signed	(Month,	Day, Year)	
	- y - 0		> imule	ļ	MD			D-	00579	999			2/20	106	)	
6	500		30. Name and address of person who	completed caus	se of death (Iter	т 23а) (Туре,	Print)			-						
.7	*	1	MANITOITA T TABELL	AT 4 3470 -												

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State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 2 2006

MANISHA J. JARIWALA MD 11637 TERRACE DR. STE.103 WALDORF, MD 20602

	*		For State Registrar	State Cortificate of Death									
•	Physicia /Medic	al	Decedent's Name (First, Middle, Robert     A. Facility Name (If not institution,	Lee	Ruby		Town or	Jr. Location of Dea	2. Date of De Month FEBRUAI	RY 25,	2006	3. Time of Death	
•	Funeral Director	er	Memorial Hospit	al & Medica	& Medical Center 7. Age (In yrs. last birthday)			Land If Under 24 Hr Hours Mir	s. 8. Date of Bir	A	legan 9. Birthp Cour	lace (State or Foreign	
	r 28a-f ahov	Director	MD Alleg		F	lintstone	ip Code			10g. Citizen	of What Cour	1X Yes 2 □ No	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mentall Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic evant, the Meulcal Examinar must be notified at ance.	by Funerai	19411 Dickerson  11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced  15. Decedent's (Specify only highest	12. Was Decedent E Armed Forces?  1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ver in U.S.	a. Decedent's Us	edent of His ecify Cuban No No	Specify:	Specify Yes or Norto Rican, etc.)	- 14. F E Spe	JSA lace - Americ lack, White, city: White Business/Inc	etc.	
		Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, L.	College (1-4or 5	h) N/.	life. DO NOT	use retired)	18. Mother's Na	ame (First, Middle				
Marylar	d 2 should by the and Mental is marked traumatic en	ToE	Robert Lee Ru  19a. Informant's Name/Relationshi Robert Ruby Sr.	iby, Sr. <sub>p (Type, Print)</sub> fathei	. 19	96. Mailing Addre 19411 Di	ss (Street a		ah (Bridg Bural Route Numb W Flints			21530	
Baltimore,	permit. Pages 1 and Department of Heeltl Importent: if Itam 27 any injury or other t		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	3 □Removal from State	20b. Place	of Disposition (Nearly, crematory or ellows Cen	other place netery		Date 2/27/2006	20c. Location Flints	n - City or To tone	own, State	
Baj			21. Signatura   Funeral Service Li	thuy	the death. Do	10	)8 Virgi	nia Avenı	Home, PA ue: Cumber		21502	Approximate	
Box 68760, —	licate be executed  Medical  Thysicien and  Thysicien and  Is the burial-transit	dical Examiner	23a. Part. Enter the disease, or of prock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Trisomy- Due to (or as:  b. Respira Due to (or as:  c. Due to (or as:  d.	18 consequenc tory a	e of): rrest e of).						Interval Between Onset and Death 7 mos.	
	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								23d. Date of delivery Month Day Year	
ords, P.O.	ne law requires that has been signed b ge 2 should be deta	è	1   Yes 2   24a. Was an autopsy performed? 1   Yes 2   No									use contribute to the cause of death?  Probably 4 Unknown	
al Reco	n: The law licate has b n: pege 2 st	e Completed										24b. Were autopsy findings available prior to completion of cause of death?  No 1 \sum Yes 2 \sum No	
ž.	Phyeician: r this certitic ral director,	To B	examiner? 1 Tes 2 No	Hospital:		Outpatient 3 🗆 [	,	r: 4 ☐ Nursing	Home 5 ☐ Resi	dence 6 🗆		y)	
Division of Vital Records,	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely tilled in by the funeral director, page	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred									al Route Number,	
ā	Hospital or a to to the total of the total of the total of the tilled in the total of the tilled in the total of the tilled in the total of the tota		4 Homicide  determined  258. Face of mily Street, factory, blinds  building, etc. (Specify)  29a. Certifier (Check only 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
	To the H within 24 To the F complete	Medicai	one)  29b. Sighature and title of certifier	and manner sta			9c. License		obiled at the time,	29d. Date sig			
	⊢s⊢ō		Maureen 1	Couran 1	20		н5598	34	F	ebruar	y 27	2006	
	7		30. Name and address of person w		•		-						
	Sta		DR. MAUREEN CON 31. Date filed (Month, Day, Year)	32. Registra	ır's Signature			, cambe	rland, MI	, 21,002			
	Registr	ar	MAR 0 2	2006	e B	Brack	3						

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [ 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Feb. 11<sup>ay</sup> 2006 5:15 pm Helena M. Rosskamp /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 13, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 NTV **Funeral** 90 Months Days Hours 1 M 2 XF Yrs. Director 094-05-0358 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Montgomery MD Germantown 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11500 Dragonfire Way 20876 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 150 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ۵ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: if Item 27 Is marked other then "say injury or other traumatic event, tra Mea. 2008. Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Teacher 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Petranowitz Lena Jockositch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa J. Ray/Daughter 11500 Dragonfire Way, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Feb. 14, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crématory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2006 21. Si nature of Juneral Service Liçensee Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD far . Iter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so ck, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Knoon **Physician** evitazione di ease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Mysc uentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed VIN CONC that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t director, page 2 s autopsy performed 2 No 2X No 1 Yes spital or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽ No 1 Sanpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 Boll MA 120 53517 tebruay 11 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Suite 213 Gaithersburg, M Frederick A ISAII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB I Registrar 2006

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		State of Maryland / Department of Health and M 3 per Dr., G85404/17/06dhb Certificate of Death	Reg.	
Physici /Media		1. Decedent's Name (First, Middle, Last)  KELVIN STANLEY REED	2. Date of Death Month Februar	0,000
Examir	ner	4a. Facility Name (If not institution, give street and number)  11 West Baltimore Street Apt 104  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death  Washington  9. Birthplace (State or Fon
Funeral Director		215-78-2647	ebruary	1,1960 Maryla
tems 23a or 28a-f show ner rust be notified at	Director	Maryland Washington Hagerstown		10d. Inside City Lin
23a or 2 181 by ny	al Dire	100. Street and Number  11 West Baltimore Street Apt 104 21740	10g.	Citizen of What Country?
유교	by Funeral	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
then "nel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired)  Laborer	ng	onstruction
n and Mental Hygie Is marked other reumatic event,	To Be C	17. Father's Name (First, Middle, Last)  Herman Leroy Reed Sr. Mary	(First, Middle, Mai	Thompson
= 12 =		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Herman L. Reed Jr. Brother 9816 Downsville Pike, H		
nent of Heal ant: If item 2 ury or other		20a. Method of Disposition  X Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Rose Hill Cemetery  02-17-	oate 200	c. Location · City or Town, State agerstown, Marylar
Department of Importent: If i eny injury or one		21. Signature of Funeral Service Licensee  Andrew K. Gare and Address of Frank Funeral Service Licensee  40 East Antietam Str		
Medical xaminer	iner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):		
/sician and e burial-tra	cal Examine	if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):		
y the attending physician and iched for use as the burial-transit	dlcal	that initiated events c.		23d. Date of delivery Month Day Year
gned by the attending I se detached for use as	by Physician/Medical	that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No  Old Helsenser  Listenser  Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)	23e. Did tobac	Month Day Year  co use contribute to the cause of death
ate has been signed by the attending page 2 should be detached for use as	Physician/Medical	that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  23c. If yes, outcome of pregnancy  1   Live birth   2   Fetal death   3   Ectopic pregnancy  4   Pregnant at time of death   5   Other (specify)		Month Day Year  co use contribute to the cause of death  2 No 3 Probably 4 Unknot  24b. Were autopsy findings available prior to completion of cause
n. After this certificate has been signed by the attending Iuneral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 5   Other (specify) 9   Unknown  23d. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 5   Other (specify) 9   Unknown  24d   Pregnant at time of death 5   Other (specify) 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25d. Was case referred to medical examiner?  1   Yes 2   Mo  1   Inpatient 2   ER/Outpatient 3   DOA  Other: 4   Nursing Home	24a. Was an autopsy performed 1 Yes 2	Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknot  24b. Were autopsy findings availa prior to completion of cause death?  1 Yes 2 No
n. After this certificate has been signed by the attending Iuneral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	that initiated events resulting in death) Last    Due to (or as a consequence of):   D	24a. Was an autopsy performed 1 Yes 2 (Check only one) me 5 (Residence 28d. Describe how in the second of the seco	Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknot  24b. Were autopsy findings availa prior to completion of cause death?  1 Yes 2 No  e 6 Other (Specify)  Injury occurred
n. After this certificate has been signed by the attending Iuneral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Medical	that initiated events resulting in death) Last    Due to (or as a consequence of):   D	24a. Was an autopsy performed 1 Yes 2 (Check only one) me 5 (Residence 28d. Describe how in the City or Town, S)	Month Day Year  co use contribute to the cause of death?  2 \[ \text{No} \] 3 \[ \text{Probably} \] 4 \[ \text{Unkno} \]  24b. Were autopsy findings availa prior to completion of cause death?  1 \[ \text{Ves} \] 2 \[ \text{No} \]  e 6 \[ \text{Other} \(Specify) \]  njury occurred  t and Number or Rural Route Number, fate)
rhis certificate has been signed by the attending ratidirector, page 2 should be detached for use as	To Be Completed by Physician/Medical	that initiated events resulting in death) Last    Due to (or as a consequence of):   D	24a. Was an autopsy performed.  1 Yes 2 (Check only one)  1 Section (Stree City or Town, Section of the cause of at the time, date	Month Day Year  co use contribute to the cause of death?  2 \[ \text{No} \] 3 \[ \text{Probably} \] 4 \[ \text{Unknow} \]  24b. Were autopsy findings availability for the completion of cause death?  1 \[ \text{Yes} \] 2 \[ \text{No} \]  e 6 \[ \text{Other} \( (Specify) \)  njury occurred  t and Number or Rural Route Number, fate)

			1 = For State Ragistrar	State of	of Maryland		artment of F tificate of	lealth and N <i>Death</i>	-	giene Reg. No.	5	06362
	Physic	ian	Decedent's Name (First, Mid	ddle, Last)					2. Date of Dea		Year	3. Time of Death
1	/Medi	cal	Patricia			nolds		- Landing of Bank	Februar	y 18,20	06	4:13 P M
7	Examir	ner	4a. Facility Name (If not institu		moerj		Leonard	r Location of Death	l	4c. County	Man	
	Funeral		St. Mary's Hosp 5. Social Security Number		7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da			place (State or Foreign ntry)
	Director		067-36-1847 Usual Residence of Decedent	1 □ M 2 💢 F	62	Yrs.	- July 5	110010	June 27			nsylvania
	yland now		10a. State 10b. Cour	nty	10c. City,	Town or Lo	cation					10d. Inside City Limits
	a-f eh	ctor	Maryland St	Mary's		C	allaway					1 ☐ Yes 2 📉 No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?
	e 23e	era era	45199 Take I		ch Road edent Ever in U.S.	12.1	1	20620		United		can Indian.
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, tiem 27 ie marked other then "naturel", or Iteme 23s or 28s-f show other traumatic event, the Medical Examinational the incliffied at	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ M  3 ☑ Widowed 4 □ Divord	arried 1 ☐ Yes	orces? 2 📉 No ve		f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify	k, White,	
21215-0036	within 72 h ene. then "natu re Medical	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	ent's Education hest grade completed)  College (		(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of work	king	16b. Kind of Bu	ısin <b>es</b> s/lr	ndustry
121	iled w Hygier ther th	S	17. Father's Name (First, Midd	2		Logi	stics Sp	ecialist 18. Mother's Nam	o (First Middle	U.S. Go		nment
Maryland	12 should be filed within hand Mental Hygiene. 7 le marked other then "reaumatic event, the Max	To Be		V. Edwards					Louise		•	
ary	and Mari	F	19a. Informant's Name/Relation			19b. Mailin	g Address (Street	and Number or Rui				
Baltimore, M	permit. Pages 1 and 2 Department of Health a Important: If item 27 le eny Injury or other tra once.		Patrick J. Ec		20b. Plac	1216 ce of Dispo	Bay Ridge sition (Name of natory or other place	e Avenue.	Annapo	lis, Mai		
Ë	Pag tment tant: I jury o		4 □Donation 5 □ Other	(Specify)				em. 2-25		Lewistor	ı, Ne	w York
Bai	permit Depar Impor eny In		21. Si maturi de uneral Servi	2/1	L			ss of Facility Bri				
			23a. Part1. Enter the disease, shock, or heart failure.	or complications that							MD	20650-0279 Approximate
>	Physician /Medical Examiner		shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	_a. MU	each line. Liple (or as a consequent	ini	uries	-				Interval Between Onset and Death
68760,	ificate be executed g physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseque							
.O. Box 68	The law requires that the death certificate has been signed by the attending ploage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐Live t	tcome of pregnanc birth 2   Fetal dr nant at time of dear own	eath 3	Ectopic pregnancy Other (specify)	,		23d. Dat	e of deliventh	ery Day Year
٦,	s that ned b e deta	by Pt	Part II. Other significant cond	itions contributing to d	eath but not resulti	ng in the ur	iderlying cause giv	en in Part I.	23e. Did to	bacco use conti	ibute to t	he cause of death?
ıd	w require been sig should b	ted k							1 🗆 Y	es 2 No	3 Prot	pably 4 Unknown
of Vital Records,		Completed				<del></del>				rmed? c	Vere auto prior to co leath?	opsy findings available mpletion of cause of
Zig	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medi examiner?	Hospital:			2 DOA Oth	26. Place of Deat				
	ding Physicien: h. After this certific tuneral director,	- To	1 X Yes 2 No 27. Manner of Death	28a. Date	of Injury 2	Bb. Time of	28c. Injun Worl	4   Nursing Ho	ome 5 ☐ Resid	lence 6 □Othe low injury occurr		(y)
ion	Attending r death. ector: After by the fune	atio	- 420	stigation 3 -	th, Day Year)	Injury		k? Yes 2 ⊠No	driver	of Mo	TOT	sion
Division	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 288. Place	of Injury - At homing, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	or or Rura	OLL ROZO
	To the Hospitel or within 24 hours atte To the Funeral Directions of completely filled in the Funeral Directions of the Fu	ledical	29a. Certifier 1 Certification Check only one)	ying Physician: To the al Examiner: On the b	best of my knowle asis of examination ner stated.	edge, death n and/or inv	occurred at the ting estigation, in my o	ne, date and place, pinion, death occur	and due to the dred at the time, of	cause(s) and ma date and place, a	nner as s and due to	tated. o the cause(s)
	To the within To the	Me	29b. Signature and title of cent		-R001	2 .	29c. Licens	e number		29d. Date signed		
			30. Name and address of person	on who completed caus	se of death (Item 2	За) (Туре, I	.>	✓ +±1 • L/ •		Februar	у 19	,2000
			PATRICIA	AronicA	- Pollat	4M>	111 Per	n Stree	t Baltin	nore, Ma	ryla	nd 21201
	Sta Registr		31. Date filed (Month, Day, Ye. FEB 2		gistrar's Signatur	k A	and .					
DH	MH 17 Rev 1/2	001				ORIGII	IAI					

			For State Registrar		Sta	te of M	laryland		rtment tificate			ınd M	ental Hy	giene Reg. No.	006	0.6	363
	Physici	an	Decedent's Name	(First, Middle,			0.1	441					2. Date of Dea	Day	Yea	r	me of Death
	/Medic Examin	al	Francis 4a. Facility Name (If	not institution,	Lee give street a	nd number		ttlemy		Γown, or I	Location o		Feb 23,		County of De		2:20pm
L	LXaiiiii	iei	Cumberla		sing H	ome			Cum					All	egany		
	Funeral Director		5. Social Security No. 216-18-1	749	6. Sex		ge (In yrs. la:	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da Nov 18	, 192	9. B	inthplace (5 Country)	State or Foreign
	/land		Usual Residence of 10a. State	10b. County				Town or Lo						- 474		10d. ins	ide City Limits
	e Man	ctor	MD	Alleg	any			Cumb					···-				Yes 2 □ No
	with the a or 2	Funeral Director	10e. Street and Nun 488 Nash						10f. Zip		1502			10g. Citiz	en of What of USA	Country?	
	death	nera	11. Marital Status	TOTICCE	12. Wa	s Deceden	t Ever in U.S	. 13. \	Vas Deced				cify Yes or No Rican, etc.)	. 1	4. Race - Ar Black, Wi		an,
250	s filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or Hems 23a or 28e-1 show yent, if a Medical Essocietrinal be notified at	by Fu	1 Never Marrie		ed 1	Yes 2 es, Give ar or Dates:	] No		I ☐ Yes 2		Specify:	, r dente i	110411, 610.)		Consilie	nite	,
3-002p	72 ho	eted	(Spec	15. Decedent'	s Education t grade comp	leted)		16a. Deced	lent's Usua kind of wor DO NOT us	l Occupat	tion uring most	of working	ng	16b. Kir	d of Busines	ss/Industry	
7 7	iene. r than '	Completed	Elementary/Secon	ndary (0-12)	Col	lege (1-4or	5+)	mach		e retired)				tir	e co.		
	be filed withing Hygiene. Id other than event, It a.M.	Be C	17. Father's Name (	First, Middle, L									(First, Middle,	Maiden	Sumame)		
ryiand	should be nd Mental marked o	7	John S 19a. Informant's Na	Stottlem		nt)		19h Mailin	n Address	(Street a			rant Sto		·	Zin Code)	
M	nd 2 lith a 27 is r trau		Elaine St			wife	1		Nash			or riora	Cumb				21502
altimore,	8 = P		20a. Method of Disp 1 🖫 Burial 2 [ '4 □ Donation	Cremation		I from State	cer	ice of Dispo metery, cren y Gap \	natory`or of	her place			2/27/2006		tstone	or Town, St	MD
galti	permit. Pa Departmen Importent: any injury		21. Signature of Fu	1/11/	11	//	IAA.			rpelli	Funer	al Ho	me, P.A.				
	THE STATE OF		23a. Part. Enter th	ne disease, or o	complications	that cause	ed the d ath.	Do not ent	108 er the mode	Virging of dying	nia Av , such as	enue;	Cumber respiratory ar	land, l	MD 215	02 Appro	ximate
	Physician		Immediate Cause ( disease or conditio	Final	only one caus	e on each	Lun		-	ncer						Onse	al Between t and Death
	/Medical Examiner		resulting in death)	P)	a	ue to (or a	s a conseque	ence of):									india
		Jer	Sequentially list cor if any, leading to im cause. Enter Unde	nditions, mediate	b	ue to (or a	s a conseque	ence of):									
/	ecuted and -transit	Examiner	that initiated events resulting in death) L	injuly	c	hua ta (ar a		nno of):								1	
8/00,	certificate be executed nding physician and use as the burial-transit	dical Ex				o io) oi eu	s a conseque	ance us).									
Õ	rtificate ng phy as the	a l	JE SEMALE.		- U												
C. BOX	death e atter d for u	Physiclan/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1	Live birth	e of pregnand 2  Fetal o at time of dea	death 3	Ectopic pro					2	3d. Date of o Month	delivery Day	Year
7.	es that the igned by the be detache	by Ph	Part II. Other signif	icant condition	ns contributir	ng to death	but not result	ting in the u	nderlying ca	ause givei	n in Part I.		23e. Did to	obacco us	se contribute	to the caus	se of death?
cords	v requires been sign should be												101	/es 2[	No 3	Probably	4 ØUnknown
Ţ	The law ate has b page 2 si	Completed											24a. Was autop perfo 1 ☐ Yes	rmed?	prior t death	o completio	dings available n of cause of o
Vital	Physician: this certific ral director,	Be	25. Was case reference examiner?	_	Hospita				-71	Othe			(Check only o				-
0	ding Phys n. After this funeral di	n: To	1 ☐ Yes 2 ☐ 27. Manner of Death	1	28a	1 ☐ Inpat Date of In (Month, D	jury 2	R/Outpatien 28b. Time of Injury		A Bc. Injury Work	41-111	-	ne 5 Resid 28d. Describe h			pecity)	
SION	eath. or: Aft	catio	1 Natural 2 Accident	5 Pending investig	ation				М	1 🗆 Y	es 2 🗆 I						
DIVISION	tal or Att	Certification:	3 Suicide 4 Homicide	determi		Place of In building, e	njury - At hom etc. <i>(So cify)</i>	ne, farm, str	eet, factory	, office		2	28f. Location (S City or Tov		1 Number or	Rural Route	Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)		Examiner: Or		of examination						and due to the ed at the time,				iuse(s)
	To th To th comp	Ň	29b. Signature and	title of certifier		2	>		29c	. License					signed (Mo		
	11		30. Name and addr	ass of person	the complete	nd cause ~	death (Item 1	23a) (Tune	Print)	D3	36766	3		150	vary	- 1, 2	
_	4									Drivo	Cur	harl	and MD	215	02		
	Sta Registr		31. Wikrama	MAR o (	2001al	192. Ingis	trar's Signatu	1824 S	CIUIT	אווע	Ouit	יחבונ	and MD	۱ ا	<i>0</i> 2		•
DH	NEGISII			שרוו ע ל	ב בטטס	ARES	was 1	r 189									

			1 - For State Registrar	State of M		nd / Depa	artme		ealth a	and M	lental Hy		06	063	64,
- A	Physici		Decedent's Name (First, Middle, Last)     ARLINE W SNEAD								2. Date of Dea Month FEBRUAR		2006	3. Time of 3:44	
	/Medic Examin		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City	, Town, or	Location of	of Death		4c. Cc	unty of Death	<u> </u>	
	Alexander a	w)	FREDRICK MEMORIAI					EDER1		0411			DERICK		
	Funeral Director		5//-24-3680	M 224F	kge (In yrs. 84	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da Sept. 2	y, Year) 24,192	9. Birthi	place (State of http:// /land	or Foreign
]	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							0d. Inside C	ity Limits
	Mary	to	Maryland Howard			Mt. Ai	ry							1 ☐ Yes	2 <b>X</b> No
	death with the Maryland me 23a or 28a-f ehow r must be notified at	Olre	10e. Street and Number				10f. Z	ip Code				10g. Citizer	of What Cou	ntry?	
	23a	ral	647 Lakeview Dri		. C	5 40	W D		771	-1-0 (0-	·		ed Sta		
3	n /z nours atter deatn with the Marylan *naturel', or Iteme 23a or 28a-1 ehow colcet Examinat invat be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? ₹No		was Deci If Yes, sp 1 Tes		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, White,		
20-5-1	within /z nours affer ene. then "naturel", or ite re Mudical Exercition	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Dece (Give	kind of w	ual Occupa ork done d use retired	luring mos	t of worki	ing	16b. Kind	of Business/In	dustry	
	rithen	mo	Elementary/Secondary (0-12)	College (1-4o 2	r 5+)	1	emak		,			C	wn Hom	2	
2	should be lifed withing the Mental Hygiene.  marked other then imatic event, tre Mental Menta	BeC	17. Father's Name (First, Middle, Last)		****				18. Mothe	er's Name	(First, Middle,	Maiden Su	mame)	· · · · ·	
3	snould be ind Mental marked o umatic eve	10	Harry S. Wagner								Elizabet				
	" = = 3		19a. Informant's Name/Relationship (Ty		1						I Route Numbe				
ָר בֿי	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any nlury or other tra		Barbara Freeburge 20a. Method of Disposition	r / Daug	20b. F	3525 A	sition (Na	ame of			ce FII		City,		and
5	ages int of t: If It y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from Stat	е	e Grov	matory or	other place	a)   [	lebru	ary				
	ortan ortan		21. Signature of Furnital Service License	09	ETH			ind Address			uffer I		iry, M		
ă	Depa Impo			<del>(5.</del>		8	E. R	idgev	ille		d. Mt.			-	
	hysician /Medical Examiner	1	23a. Part1. Enter the difference or complished, or heart failur. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or a	20 C	ARY quence of): OLON					SEASE			Approximatinterval Bet Onset and	tween
5	incate be executed physicien and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a											
.0.	that the death certificate to do by the attending physic detached for use as the to the to the total to the total to the total to the total to the total to the total to the total total to the total	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2√2 No 9 □ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	of death 3	⊒Ectopic ⊒ Other (s	oregnancy specify)				230	i. Date of delive Month	•	Year
colus, r	w requires mai s been signed t 2 should be dett	Ď.	Part II. Other significant conditions con  DTABETES MEL	•	but not res	sulting in the u	inderlying	cause give	n in Part I	,			contribute to t √o 3 ☐ Prot		
000	Ine law requires that the ite has been signed by th bage 2 should be detache	Completed	HYPERTENSION	7							24a. Was autop perio 1 Yes	an 2 osy ormed? 2 No	24b. Were auto prior to co death? 1 \( \text{Yes}		available cause of
Aita	ertifica octor,	Be	25. Was case referred to medical examiner?							of Death	Check only o				
5	this c	ည	1 ☐ Yes 2 No 27. Manner of Death	lospital:		ER/Outpatier			4 🗀 140		me 5 Resid			y)	
5	After After funer	to	1 Natural 5 ☐ Pending	28a. Date of Ir (Month, I	Day Year)	28b. Time o Infury	м	28c. Injury Work	res 2 🗆		28d. Describe h	iow injury o	ccurred		
DIVISION OF	after deat Director: Jin by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of to	injury - At h etc. <i>(Speci</i>	ome, farm, str fy)	reet, facto				28f. Location (S City or Tov		lumber or Rura	il Route Nun	nber,
	To the hospital or Attending Prysician: The law within 24 hours after death within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 and an additional page 2 and 25 and 2	ledical C	23a Cartifier (Check only one) 1 Cartifying Physical Exami	uician: To the bei ner: On the basis and manner	of examina	wiedy desit ation and/or in	t ceruire vestigation	d at the ten n, in my op	e data an pinion, dea	id place i ath occurr	and due to the ed at the time,	cause(s) and pl	d tranner as s ace, and due to	ated the cause(s	s)
	within To the	Me	29b. Signature and title of certifier				2:	9c. License	number				igned (Month,	Day, Year)	
			> mary P. H	mull	MO			D4	607	75		2/1.	5/06		
1)	5	9	30. Name and address person who co	empleted cause of	f death (Iter							2.5		1700	
-	Sta	ale.	Mary P. Howell,	M.D. 6	5C Th	omas J	ohns	on Dr	ive	Fre	derick,	, Mary	Tand 2	1/02	
	Regist		31. Date filed (Month Cay Year) 7 2	006	ever	ature A	perl								

		•	For State Registrer	State	of Mary	land / Depa	artment of l rtificate of			•	giene Reg. No.	96	06365
			1. Decedent's Name (First, Midd	lle, Last)						2. Date of De	ath Day	Vone	3. Time of Death
	Physici /Medio		Margaret Daley	Schwartze	€					Februa		2006	19:58M
}	Examin		4a. Facility Name (If not institution	on, give street and no	umber)		4b. City, Town,	or Locatio	n of Death		4c. Cou	nty of Death	1
1			Anne Arundel Me	edical Cer	ıter		Anna	polis	5		Ar	ne Ar	rundel
	Funeral		5. Social Security Number	6. Sex	T	yrs. last birthday)	If Under 1 Year Months Days	If Und	er 24 Hrs.	8. Date of Bir (Month, Da			place (State or Foreign intry)
	Director		220-07-4281	1 ☐ M 2 🔀 F	8	35 Yrs.	World Days	Tiouis		Apr 22	, 1920		yland
	<u>م</u>		Usual Residence of Decedent		140	c. City, Town or Lo			•				10d. Inside City Limits
	shov	_	10a. State 10b. County		10	•							1 ☐ Yes 2 🛣 No
	89-1	ctc		Arundel		Arnol							
	or 2	Dire	10e. Street and Number				10f. Zip Code				10g. Citizen		intry?
	ath w	rai	557 Broadwate					1012			14.5	USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show many injury or other treumatic event, the Medical Examinational be rudified at Once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Ma  3 ☑ Widowed 4 ☐ Divorce	If Yes, G	orces? 2 XNo live		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🔀 No	ban, Mexic	can, Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White cify: W.	
0-0	72 ho	Completed		nt's Education est grade completed	0	16a. Dece	dent's Usual Occu kind of work done	ipation	ast of work	ina	16b. Kind of	Business/I	ndustry
21	thin 6.	npie	Elementary/Secondary (0-12)	- i	(1-4or 5+)	life.	DO NOT use retir	ed)					
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pu	al Hy	Be	17. Father's Name (First, Middle	, Last)				18. Mo		e (First, Middle		name)	
<u>yla</u>	Ment Ment arke	ဥ	Frank Daley							aret Ba			
Maryland	12 should be filed within : h and Mental Hygiene. 7 Is marked other then "! treumatic event, the Med		19a. Informant's Name/Relation				ng Address (Stree						
	and ealth n 27 ner tr		Joan Ferris/S	ister			66 Cheve	rly I			Burnie,		
altimore,	Pages 1 ment of Ho ent: If iter ury or oth		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		- 01-1-	Parkwood	Cemetery or other pl.	Y	Febru 20	ary 18	Balti	in-City or 1	
Balt	permit. Depart Import any inj		21. Signature of Juneral Service	Licensee Day	11	4	2. Name and Addi arranco 95 Gov.	& Sor Ritcl	ns, P. Lie Hv	A. Se	verna I verna l	Park F	uneral Home MD 21146
0,	Physician and Medical Examiner and physician	Examiner	23a. Part 1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cesass or Hijur) that initiated events resulting in death) Last	a	o (or as a co	r. 1	45 Cma	ring, such	as cardiac o	or respiratory a	irrest,		Approximate Interval Batween Onset and Death
P.O. Box 68760,	death certif e attending d for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4⊟Preg 9⊟Unk	birth 2 gnant at tim	Fetal death 3(	□Ectopic pregnan □ Other (specify)					Date of deli	Day Year
	w requires that the been signed by the should be detache	b	Part II. Other significant condit	celuie	death but n	ot resulting in the t	inderlying cause g	riven in Pa	urt I.				the cause of death?  bably 4 Wunknown
I Records,	The law ate has b page 2 st	Completed								24a. Was auto perf 1 🗆 Yes		b. Were au prior to death?	topsy findings available completion of cause of 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?							h (Check only			
of \	Physic this c	2	1 ☐ Yes 2 💢 No		Inpatient	2 ER/Outpatie				me 5 Res			city)
u	ding P. h. After t	on:	27. Manner of Death  1 X Natural 5 ☐ Pend	/8.40	e of Injury onth, Day Ye	ear) 28b. Time o	W			28d. Describe	how injury oc	curred	
sio	eath.	cati	2 Accident inves	tigation				⊒Yes 2			(0)		1.5
Division	s after d	Certification;		mined 286. Plac	ce of Injury Iding, etc. (\$	<ul> <li>At home, farm, st Specify)</li> </ul>	reet, factory, office	Э			(Street and Nu wn, State)	imber or Hu	ral Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical (	29a. Certifier (Check only one) Certify	ing Physician: To the Examiner: On the and ma	he best of m basis of ex unner stated	amination and/or in	th occurred at the evestigation, in my	time, date opinion, c	and place, death occur	and due to the red at the time	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and title of certif	Special				-	052		29d. Date sig	12 (06	n, Day, Year)
			30. Name and address of person of verse Black Bl	n who completed ca	2001	h (kem 23a) (Type	Print) howay	, and	rapoli	7, MD			
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea	5 2006	Pirgistrar's	Signature	how						

				• •				nk. Ensure All f Health and Me	•	_	
				1 _ State Registrar		Ce	rtificate d	of Death	Reg	No. 116	06366
				Decedent's Name (First, Middle, Last)					2 Date of Death		3, Time of Death
		Physici		James H. Simpson				1	-Month Fe Druary	Day Year 7, 2001	0 10:30 AM
		/Medio Examin		4a. Facility Name (If not institution, give street	and number)	<del></del>	4b. City, Tow	n, or Location of Death	0	4c. County of Dea	
	1	Exami	E	Lions Manor Nursin	ia Home	)		rland		Allegany	,
		Euparal		5. Social Security Number 6. Sex	<u> </u>	je (In yrs. last birthday,	If Under 1 Ye		8. Date of Birth		thplace (State or Foreign
		Funeral Director		217-10-6212 12M	2□F 91	Yrs.	Months Da	ys Hours Min.	8. Date of Birth (Month, Day, Ye 6-11-19)	ear) C	WV
				Usual Residence of Decedent							
		yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
		Mar B-1-	ţ	PA Bedford		Hyndman					1 ☐ Yes 2 Ø No
		1 the	Director	10e. Street and Number			10f. Zip Cod	ie	10g.	Citizen of What C	ountry?
-		h with		146 3rd Ave.			15	545		USA	
-		deat	Funeral	11. Marital Status 12. W	as Decedent med Forces?	Ever in U.S. 13.	Was Decedent	of Hispanic Origin? (Spec Cuban, Mexican, Puerto F	city Yes or No-	14. Race - Am	
S	9	after or Ite	2	1 ☐ Never Married 2 ☐ Married 1	☐Yes 2☑	No	1 ☐ Yes 2 Ø		ilcari, etc.)	Black, Whi	·
0	8	nal.	by	3 ✓ Widowed 4 □ Divorced Y	Yes, Give ear or Dates:		TLITES ZIE	но зреспу:		Specify: WY	ue
am	5-0036	72 hc	ted	15. Decedent's Education (Specify only highest grade com	nleted)	16a. Dece	dent's Usual Oc	cupation	161	o. Kind of Business	/Industry
10	7	thin thin	Completed		ollege (1-4or			one during most of workin tired)			
1)	21	ygien /gien ler th	S		2	uncce	a merno	dist Minist		_Ministry	<u> </u>
_	pu	al Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		den Sumame)	
Ž	yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 ehow aumatic event, Ite Macical Examinet must be notified at	ဥ	Rezin H. Simpson				Sophia	teaster		
impson	Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Ie marked other than "natural", or Items 23e or 28e-1 ehow other traumatic event, the Madical Exemitier must be notified at		19a. Informant's Name/Relationship (Type, P	rint)	19b. Maili	ng Address (Str	reet and Number or Rural	Route Number, C	ity or Town, State,	Zip Code)
9		1 and 2 Health tem 27		James May Nepheu	,	PO	Box 684	Hyndman, P			
E	ore	of H		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov	al from State	20b. Place of Disponentery, cre	osition (Name of matory or other	f Da	ate 200	. Location - City or	Town, State
:0	Ĕ	Pag nent snt: I		' 4 ☐ Donation 5 ☐ Other (Specify)	ai ii oiii otato	Hundman	Cemeter	.y 2-11	-06 H	yndman, P	PA .
(1)	Baltimore,	permit. Pages 1 and 2 Department of Health 8 Important: If item 27 I any injury or other tra		21. Signatur of uneral Service Licensee	1	2	2. Name and Ac	ddress of Facility Ada:	ms Family	y Funeral	Home, P.A.
	m	8989		talt C. All	in.	/ 4	04 Deca	tur Street,	Cumberla	and, MD	21502
				23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that cause use on each li	The death. Do not en	ter the mode of	dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	A	الماع و دروادها		-Dievatenly	~		Onset and Death
		/Medical		resulting in death)		a consequence of):	C ().	,,, com, ooco,,,	- 0100	, , ,	YEMMY
		Examiner		Designation of the second of t							
			ner	Sequentially list conditions, b	Due to (or as	a consequence of):					
		be executed sician and burial-transit	Examiner	that initiated events							
	o,	an a	_	resulting in death) Last	Due to (or as	a consequence of):					
	Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Medical	d							
	89	Jeath certificate b rattending physic I for use as the b	Med	IE EENALE							
	ŏ	th ce endii r use	ar/	230. Was decedent pregnant	yes, outcome	of pregnancy 2 ☐ Fetal death 3{	⊒Ectopic pregna	ancv		23d. Date of de	·
		the death	1000	1 \(\superstant \text{ Yes 2 \(\superstant \text{ No } \)			Other (specify			Month	Day Year
	P.O.	that the de ed by the detached	h X	9 🗆 Onknown					-		
		res tha igned be del	by F	Part II. Other significant conditions contribut		out not resulting in the u	inderlying cause	given in Part !.			o the cause of death?
	ord	w require been signature		ABDOMINAL AGAL	re A	nearten	-		1 🗌 Yes	2 No 3 ₽	robably 4 🗍 Unknown
	S	aw ra s be 2 sh	ple						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	Ä	The law ste has bage 2 s	Completed						performed 1 ☐ Yes 2 🔀	t? death?	2 No
	ita	ian: rtifica stor, p	0	25. Was case referred to medical				26. Place of Death			
	f V	Phyaician: The la r this certificate has ral director, page 2	To B	examiner?	al: 1 🔲 Inpatio	ent 2 ER/Outpatie	nt 3 DOA	Other: 4X Nursing Hom	e 5 Residence	e 6 □Other (Spe	ocity)
	0	ding Phy h. After thi funeral (		27. Manner of Death 28	a. Date of Inju (Month, Da	ury 28b. Time o	f 28c. I	njury at 2 Work?	8d. Describe how i	injury occurred	
	Ö	ath. r: Af	atlo	2 Accident investigation		, , ,		1 ☐ Yes 2 ☐ No			
	Division of Vital Records,	r Atte er de recte by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of In	jury - At home, farm, st tc. (Specify)	reet, factory, offi	ice 2	Bf. Location (Stree City or Town, S	t and Number or R	ural Route Number,
		talo rsaft alDi	Cer								
		To the Hospital or Attending Planting 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	cal	29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: C	: To the best on the basis of	of my knowledge, dea	h occurred at the	e time, date and place, a	nd due to the caus	e(s) and manner a	s stated. e to the cause(s)
		the hin 24	Medical	one) a	nd manner st	ated.					
		To To	2	29b. Signature and title of certifier	$\mathcal{A}$	11		ense number		Date signed (Mon	. ,
		2		1 June	Oon		- 1	>42054	Fel	oruary	B,2006
		4	A	30. Name and address of person who comple	oci illa	death (Item 23a) (Type	Print)	542054 Dr. Cumbe	Salar Transaction	0	6750
	-		S	Grey Donald Sc	N. M.	913	seton	Dr. Cumbe	rland,	116 911	50 A
		Sta		31. Date filed (Month, Day, Year)	. 77		Coule		,		
		Registr	ar	FEB 0 9 2006	130	Eur B.	GOODIE!				

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	Physic /Medi		1. Decedent's Name (First, Middle, L Iva Blanche SEAI							7	ate of Death Ionth	Day	2006	3. Time of Death	
	Examii	ner	4a. Facility Name (If not institution, g Washington Count	y Hospita	1		На	gersi					nty of Death hingto	on	
100	Funeral Director		5. Social Security Number 6.  214-46-5372  Usual Residence of Decedent	Sex 7. 1 ☐ M <b>2½</b> ☐ F	Age (In yrs. Ia 94	st birthday) Yrs.	If Under Months		Hours N	Vin. (N	ate of Birth fonth, Day, 1e 23			lace (State or Fore try) inia	gn
	h the Maryland or 28a-f show	Director	10a. State 10b. County  Maryland Washin 10e. Street and Number	gton	10c. City,	Town or Lo	erstor 10f. Zip				100	g. Citizen o	1 f What Coun	0d. Inside City Limi 1 ☐ Yes 24 ☐ N	
900	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criment of Health and Mental Hygiene.  criant: if item 27 is marked other then "netural", or items 23e or 28e-f show injury or other traumatic event, the Medical Exeminan must be notified at a.	by Funeral	12135 Walnut Poi 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	nt West  12. Was Decede Amed Force 1 Tyes 2y If Yes, Give Year or Date	s? [] No		Was Deced f Yes, spec	lent of Hi offy Cubai	L 740 spanic Origin' n, Mexican, P Specify:	? (Specify Y uerto Rican	es or No- , etc.)		ace - Americack, White, e	etc.	
1215-0	within 72 h ene. then "netu he Medicel	Completed	15. Decedent's (Specify only highest g	College (1-4	or 5+)	16a. Deced (Give life. I	dent's Usua kind of wo DO NOT us	rk done d	uring most of	working	16	6b. Kind of	Business/Ind	lustry	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then "raumatic event, the Me	To Be Co	3 17. Father's Name (First, Middle, Lass Solon J. Alger				Iomema			a Burn	ıs	aiden Suma	,		
	Pages 1 and 2 st nent of Health and ant: if item 27 is n ury or other traun		19a. Informant's Name/Relationship  Gary L. Sea1 - S  20a. Method of Disposition  1 X Burial 2 □ Cremation 3	on			Walı	nut I	nd Number of Point V		la ers	town,		1740	
Baltimore,	permit. Page Depertment of Important: if any njury or once.		4 □ Donation 5 □ Other (Spec 21. Signature → Funeral Service Lice	**	Rose		. Name an	d Addres	2/1 s of Facility son Blv	_	ch Fu	neral	town, Home Md. 2	Maryland	-
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	one cause on each	sed the death. I line.  as a conseque							t,		Approximate Interval Between Onset and Death SUDDEN	
8760,	Examine pe executed hysician and he burial-transit	ilcai Examiner	Sequentially list conditions, and a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PAR	as a conseque	J C LG								45 + KS	
P.O. Box 6	The law requires that the death certific te has been signed by the attending p. page 2 should be detached for use as s	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal d	leath 3 🗌	Ectopic pro						ate of deliver	y Day Year	
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death	but not result	ing in the ur	iderlying ca	iuse give	n in Part I.	2		cco use cor		e cause of death?	'n
al Reco	i: The law re icete has bee r, page 2 sho	Completed								_	4a. Was an autopsy performe □ Yes 2□		prior to com death?	sy findings availab pletion of cause of 2 No	Θ
Division of Vital Records,	Attending Physician: Thir death. ector: After this certificete by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 Vo  27. Manner of Death  1 Autural 5 Pending investigatic 2 Accident 6 Could not 1	28a. Date of li (Month, I	Day Year)	8b. Time of Injury	M 2	A Other  Bc. Injury Work'  1  Y	4 🗀 Nursin	g Home 5			her <i>(Specify)</i> rred		
N N	To the Hospital or Attan within 24 hours after deal To the Funeral Director: completely filled in by the	Certifi	4 Homicide determined	building,	etc. (Specify)					Ci	ty or Town, S	State)		Route Number,	
	To the Hos within 24 ho To the Fun completely	Medical	(Check only one)  2 Medical Exa  29b. Signature and title of certifier	hysician: To the be miner: On the basis and manner	or examinatio	n and/or inv	estigation,	in my opi	nion, death o	ace, and du ccurred at ti	he time, date	and place,	, and due to t	the cause(s)	
)	- 3 H S		Mungh	hhen,	w		D		104	U			7 - 20	oo6	
5.	2		30. Name and address of person who				,	14	4LERS	NWOT	v, M	D 2	1740		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 7 2	32 Regis	strar's Signatur	Spe	the				J				

State of Maryland / Department of Health and Mental Hygiene 06368 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Goldie Marie STOUFFER 7:05 February 14 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 21 F 219-46-3712 90 Yrs. Director 10, 1915 Maryland Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f show in then "neturel", or items 23a or 28e-f show the Medical Exprine must be notified at 1 ☐ Yes 2∑ No Maryland Directo Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10116 Sharpsburg Pike 21740 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker 0 her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Herman David Barkdoll Katherine Alice Sheffler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 Is m any injury or other traum once. Jean M. Weaver - daughter 423 Clarendon Avenue, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery ! 4 □ Donation 5 □ Other (Specify) 2/18/06 Hagerstown, Maryland 22. Name and Address of Facility + Funeral Service Licensee 21. Signature MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ACUTE MYOCALDIAZ INFARCTION /Medical Due to (or as a consequence of): Examiner CONGESTIVE Honei FM LURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine I by the attending physicien and stached for use as the burial-transit The law requires that the death certificate be executed RENAZ MUITE that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by HYPONATREMIA 1 Yes 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b Time of 28d. Describe how injury occurred Certification: 1 Natural 5 🗌 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation М 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) nave D0062006 30. Name a address of person o completed cause of death (Item 23a) (Type, Print) F5-C 251 Cast 31. Date filed (Month, Day, 32. Signature State B. Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vaar **Physician** 4:00P M Hadassah Stern February 11, 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bedford Court Nursing Home Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Yrs Director 94 June 3, 1911 New York 125-10-5480 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 1 Yes 2 No Directo Silver Spring Md Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3701 International Drive, # 725 20906 U. S. A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Accountant Dept. of Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Philip Stern Lena P. Pfeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Anna Bernstein - Sister 3701 International Dr., # 725, Silver Spring, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2/14/2006 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licenseg Sonald ( 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ XNo 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed þ page 2 should be 1 Yes 2 No 3 Probably 4 Munknown <u> Dementia (Vascular)</u> Completed 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? this certificate has autopsy performed? 1☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3□ DQA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🖾 Natural 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 13, 2006 15 D050545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7513 New Hampshire Avenue, Takoma Park, Maryland Dr. Godswill O. Okoji

State Registrar 31. Date liled (Month, Day, Year)

FEB

15

2. Registrar's Signature

1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $^{\text{Da}}$ Y 9 Physician FEBRUARY 2**0**06 Robert Pau1 Sievers 21:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) 1 **X**M 2 ☐ F Yrs. Director 496-54-5369 54 June 29,1951 Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other than "natural", or items 23a or 28a-f shov vent, the Madical Exeminer must be notified at 1 ☐ Yes 2X No Directo Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28717 Lockes Hill Road death 20659 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐Yes 2 ZNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physical Scientist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental H 27 is marked of traumatic ever ဥ Robert Henry Sievers Marie Theresa Benz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar important: if item 27 is any injury or other trau Lauretta A. Sievers / Wife 28717 Lockes Hill Road, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 2-25-2006 St. Louis, Missouri Te of Funeral Service Acensee 22. Name and Address of Facility Edward N. Brinsfield, Jr. Brinsfield Echols Funeral Home, P.A. 30195 Three Notch Road, Charlotte Hall, M00052 MD 20622 Approximate Interval Between Prise and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTA LUNG **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the all d be detached for 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificete has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 26 No Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 LNO Certification: To 1 Impatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after deeth.

To the Funeral Director: After t
completely filled in by the funera 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 5 To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and (itte of certifier 29c. License number 29d. Date signed (Month, Day, Year) DP096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder S. Gill, M.D., 24035 Three Notch Road, Hollywood, MD 20636 31. Date filed (Month, Day, Year) State FEB 2 1 2006 Registrar

PAUL

ROBERT

		For State Registrar	State	of Maryla		artment of H rtif <u>i</u> cate of L		and Me	,	giene Reg. No.	006	063	71
*		1. Decedent's Name (First, Middle	, Last)					:	2. Date of Dea	ath Day	Year	3. Time o	f Death
Physici /Medio		Carol Rose Todd							2	14	2006	9:48	РМ
Examir		4a. Facility Name (If not institution	give street and	number)		4b. City, Town, or	Location of	f Death		4c. 0	County of Death		
		10233 Bent Creel	k Rd.			0cean	City			W	orceste	r	
Funeral		5. Social Security Number	6. Sex		s. last birthday)				8. Date of Birt (Month, Da)	h v Year)	9. Birth	place (State	or Foreign
Director		225-78-2610	1 □ M 21€ F	52	Yrs.	WOTHIS Days	riours	IVIIII.	10/17/	1953	Queb	ec, Ca	ınada
ъ.		Usual Residence of Decedent		10- (	Ch. Taus and							10d Incide C	12a - 1 1 - 14 -
aryta hov	_	10a. State 10b. County		100.0	City, Town or Lo	ocation						10d. Inside C	2 □ No
Ba-f-	Director	MD Worce	ester	0	cean Ci	ty			-				2 140
라 다 0.7 2	- Pi	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cou	ntry?	
23a	ai	10233 Bent Creel	k Rd.			218	42			US	A		
dez - dez	Funeral	11. Marital Status		ecedent Ever in Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig n, Mexican,	gin? (Spec , Puerto R	ify Yes or No- lican, etc.)	- 1	<ol> <li>Race - Ameri Black, White.</li> </ol>		
affe affe		1 Never Married 2 Marri	If Yes,			1 ☐ Yes XXNo	Specify:				Specify:	White	
be filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland of other than "natural", or Iteme 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☒ Divorced		r Dates:									
72 nat	Completed	15. Decedent (Specify only highes		d)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	lurina most	t of working	g	16b. Kin	d of Business/Ir	idustry	
P o di	d m	Elementary/Secondary (0-12)	College	e (1-4or 5+)			,			0		<b>G</b> .	
tygie Ther t		12 17. Father's Name (First, Middle, I	l cath		cler	k/manager	19 Mether	de Nome	(First, Middle,		venienc	e Stor	e e
be fi	Be										·		
should and Men marke	မ	Patrick Ernest			1						n Phill		
2 sh 2 sh 1 and 1 e m	ĺ	19a. Informant's Name/Relationsh				ng Address (Street a							
1 and 2 Health a m 27 I		Christopher Wil	liam Tod			3 Bent Cr	eek R	.d., (					
Pages 1 nent of H int: If Its		20a. Method of Disposition 1 Darial 2 Coremation	3 Removal fro	m State	cemetery, cre	osition (Name of matory or other place					ation - City or T		
Pag men ant: ury		4 Donation 5 Other (Sp		Ca	-	lopen Cre					kford,		
permit. Pages 1 and 2 should be filed within Department of Headle and Mental Hygiene. Important: If Item 27 is marked other than any injury or other fraumatic event, Ital Magnee.	:	21. Signature of Funera Service I	Licensee	. 1		2. Name and Addres			_	•		ome	
_		23a. Part1. Enter the disease of	complications the	at caused the de					<u>.</u>		011	Approxima	te
		shock, or heart failure. List	only one cause	each line.		,					2	Interval Be	tween
Physician		Immediate Cause (Final disease or condition resulting in death)	a	Met	SSTA	TIC (	-AR	CIN	10 mz	- Of	DVa	IN	
/Medical Examiner		Tooling in doubly	Due	to (or as a conse	equence of):	C-11	1		4 10	/	10 - 12		
		Sequentially list conditions,	b	to (or as a conse	C []	Cell	6	-UU	na	Ca	nce	<i></i>	
ed sit	- Ju	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		to (or as a const	aquarica or).								
ate be executed shysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c	to (or as a conse	equence of):			<del></del>					
be ey icien buria	E E			(	- , , -								
i jag	dical		d					-					
leath certific attending p	/Me	IF FEMALE:	23c Hyas	outcome of preg	manov			-					
ath o	ian	23b. Was decedent pregnant in the past 12 months?	1 Liv	e birth 2 ∏ Fe egnant at time of	etal death 3	Ectopic pregnancy				23	<ol> <li>Date of deliv</li> <li>Month</li> </ol>	- ,	Year
the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Un		rdeath 5L	Other (specify)							
that the de led by the a	F.	Part II. Other significant condition	As contributing to	death but not re	esulting in the u	nderwing cause give	on in Part I		23a Did to	obacco us	e contribute to t	he cause of	death?
uires ti	þ	50121	110	D150	00/	? D	or in real ( ).		18			bably 4	
w requi	Completed	06120	10		Ruce				1 2 1	103 2	1140 0 1710		
e law has b	ple								24a. Was autop	sy /	24b. Were auto prior to co	opsy findings impletion of a	available cause of
The ate h page	5								perfo 1 ☐ Yes	rmed? 2 No	death?	2 □ No	
hysician: The la	Be (	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	ne)			
nysko nis ce dire	၉	1 Yes 2 No	Hospital:	☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	er: 4 🗌 Nur	rsing Hom	e 5 Hesio	dence 6	Other (Special	fy)	
ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Da	te of Injury Ionth, Day Year)	28b. Time o	f 28c. Injury Work	at c?	28	8d. Describe h	now injury	occurred		
ath. A fu	atic	2 Accident investig	ation				Yes 2 □ N	No					
ar de	tifle	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	288. Pl	ice of Injury - At	home, farm, st	reet, factory, office		28	Bf. Location (S City or Tox	Street and	Number or Rur	al Route Nur	nber,
s aft al Di	Certification:								,	,			
To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompiletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical	Examiner: On the	basis of exami	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	ne, date and pinion, deat	d place, ar	nd due to the	cause(s) a	and manner as s place, and due t	stated. o the cause(	s)
the the mplet	Med	one)	and m	anner stated.		20a Liannes	numbar			:)Od Data	ninned (Month	Day Veed	
Twit To Do		29b. Signature and title of certifier	1/			29c. License	C C	0	-7	A CO	signed (Month,	Day, rear)	
		7 4. (	145/10	γ,		1) 2	- 1 600	- 0	2	02	/16/	06	
		30. Name and address of person	who completed c	ause of death (It	em 23a) (Type,	Print)	1 1	7	1	/	1	./1 0	
DH 15		140 E CA	11011	52.	2011	bury,	M	<b>U</b> .		mn	TY 1A	Y 1012	, M.L
Sta		31. Date filed (Month, Day, Year)	32	. Registrar's Sig	nature	, , )'					/	(	,
Regist	ar	FFD 1	6 2009	Beder	*	pade							
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			For State Registrar	State of Maryland			f Health and I of Death	, ,	iene og. Nø. 006	06372
4	A Company		Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	Physici /Medic		Steven	Bradley		Twig	g	<b>S</b> a (	57 O	0320 "
)	Examin		4a. Facility Name (If not institution, give str	reet and number)			n, or Location of Deat	1	4c. County of Dea	
Į,			Jacred Hearet	- HORDMAL		Car	berlau		Allego	iny
	Funeral	V	5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Y Months D	ear If Under 24 Hrs. Bys Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director	2	216-/2-6294 A	M 2□F 50	Yrs.		,	11/15/19		yland
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c City	. Town or Lo	cation				10d. Inside City Limits
	sho:	5		, , , ,						1 ☐ Yes 2√∑ No
	18a-1	Director	MD Allegany			01dtc		1 1	Og. Citizen of What C	1
	with a or		10e. Street and Number	+ Didaa Daad			555	"	USA	ountry:
	deeth with the Maryland ims 23a or 28a-f show	Funeral		t Ridge Road  2. Was Decedent Ever in U.S	13 \		of Hispanic Origin? (S	nacify Yas or No-	14. Race - Am	erican Indian
	Itam Iran	'n	11. Marital Status 12  1 □ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	10.1	f Yes, specify	Cuban, Mexican, Puer	o Rican, etc.)	Black, Whi	
0030	hours after tural', or Ita	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2∏	No Specify:		Specify:	White
2	2 hou	Completed	15. Decedent's Educa		16a. Deced	lent's Usual O	ocupation	41	16b. Kind of Business	
2 2	within 72 ene. then "ns re Medic	ple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life. L	DO NOT use r	one during most of wor stired)	xing		
7	d with	E	12	conego (* ver e.)	I	aborer			Municija	1
and	be filed within 72 hours after deeth with the Marylan it all tyyliene. Id other than "natural", or Itama 23a or 28a-1 ahow avant. It a Medical Examirar must be notified at	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M	faiden Surname)	
<u>a</u>	should be filed and Mental Hygi marked other matic avant, I	To	Kenneth	Richard	T	wigg	Mary	Ват	bara	Payne
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a Informant's Name/Relationship (Type Kim	a, Print)	19b. Mailin	g Address (S	reet and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
_	1 and 2 Health em 27 l		-Kimberly Twigg / wi	ife	14700	Walnu	t Ridge Ro	ad, Oldto	own, Maryl	and 21555
9	of Hear of Hear fitem		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Rei		ace of Dispo metery, cren	sition (Name on natory or other	place)	Date	20c. Location - City or	Town, State
altimor	permit. Pages Department of I Important: If its any injury or o'		4 Donation 5 Other (Specify)	Sun	set Me	morial	Park 02/1	0/2006	Cumberlan	d, MD
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n	80 E E 8		Lahet Cas	lame	4	04 Dec	atur Stree	t, Cumbei	land, MD	21502
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death.			4	-		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	B: 10 toral	Cer	ebral	Ischem	ic STI	OKE	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque						
	Examiner		Sequestially list conditions	CARDIA	c AI	RRE	57			INFEK
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	nd trans	Examiner	that initiated events c.	ACUTE	my	ocaro	lial in	Karct	on	/***
Š	e exe		resulting in death) Last	Due to (or as a conseque	ence of f.					
8/PC	death certificate be executed e attending physician and nd for use as the buriat-transit	dlcal	d.							
٥	leath certific attending p	(0)	IF FEMALE:	М						
X Q Q	ath co	Iclan/M	23b. Was decedent pregnant in the past 12 months?	<ul> <li>c. If yes, outcome of pregnant</li> <li>1 ☐ Live birth 2 ☐ Fetal</li> </ul>	death 3 □	Ectopic pregr			23d. Date of de Month	livery Day Year
- -	the a	slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	ath 5∟	Other (specif	y)			,
7.	n requires that the de been signed by the should be detached	Physi	Part II. Other significant conditions conti	ributing to death but not resul	lting in the ur	nderlying caus	e given in Part I	23e. Did tob	acco use contribute t	o the cause of death?
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Hecords	requ	ompleted								
e S	E 9 01	du.						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
		ပိ								s 2 No
VII	Physician: The Is this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	espital:			Othor	ath Check only on		
0	<u>~</u> .≅ ₽	5	TE TES 23 NO	1 Munpatient 2 E	P/Outpatien				nce 6 Other (Spe	ecify)
	ing F After uner	i o	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	280. Describe no	w injury occurred	
<u>s</u>	Hend Jeath tor: the t	cat	2 Accident investigation 3 Suicide 6 Could not be	On a Place of Laive. At hou	ma farm etc			28f Location (St	reet and Number or F	Pum I Poute Number
Division	or A after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	)	eet, lactory, or	iice	City or Town	, State)	larar riodio rvambor,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 ertifying Physi	cian: To the best of my know	viedne death	1 Occurred at t	ne time, date and place	and due to the or	use(s) and manner a	s stated
	24 hg Fun Fun	Medical	(Check only 2 Medical Examine one)	er: On the basis of examinati and manner stated.	ion and/or inv	vestigation, in	my opinion, death occu	irred at the time, di	ate and place, and du	e to the cause(s)
	o thi o tha omple	Me	29b. Signature and it e of out ther			29c. L	cense number	2	9d. Date signed (Mon	th, Dey, Year)
	- s - ō			1 Ma		0	54756	E	ha must	7 700h
7	63	0	30. Name and address of person who com	noleted cause of death (Item	23a) (Tyne	Print)	- 1100		e bruary ?	, 2000
			DR Robert Kai		02D	rive	Cumber	avo,	MD 215	502
	s sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure			· · · · · · · · · · · · · · · · · · ·		
	Registi		FEB 0 8 200	16 Danie	K	Social 1				

		1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F			ene g. No. 0 0 6	06373
		1. Decedent's Name (First, Middle,	Last)				2. Date of Death	1	3. Time of Death
Physic		Ivadean		Turley			Month Februar	Day Year y 6, 2006	10:30 A M
/Med Exam		4a. Facility Name (If not institution,	give street and number)	202201	4b. City, Town, o	r Location of Death		4c. County of Deat	
		Allegany County	Nursing & F	Rehab. Ctr	. Cumber	rland		Allega	ny
Funera			S. Sex 7. Age	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birtl	nplace (State or Foreign untry)
Directo	r	219-54-1748 Usual Residence of Decedent		7 Yrs.			10/08/1		nsylvania
rylar		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
e Ma Sa-f g	5	MD Alle	gany	Cum	berland				1 🖾 Yes 2 🗆 No
or 28	Oire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
Baltimore, IMaryland 21213-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, Ira Medical Estring and injury or other traumatic event, Ira Medical Estring and injury or other traumatic event, Ira Medical Estring at Irangal Estring and injury or other traumatic event, Ira Medical Estring at Irangal Estring and injury or other traumatic event, Ira Medical Estring at Irangal Estring at	by Funeral Director	639 Lincoln				502		USA	
er de tems	nue	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
s after	<u> </u>	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ∐Yes 2 X No If Yes, Give Year or Dates:	9	1 ☐ Yes 2 ☒ No	Specify:		Specify:	hite
Z1Z13-UU35 od within 72 hours af gjene. er than "natural", or it it Medical Exert.	8	15. Decedent's		16a Dece	dent's Usual Occup	ation	1 ,	6b. Kind of Business/	
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Z should and Men la marke aumatic	F	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number,	City or Town, State, 2	lip Code)
and 2 and 2		Carolyn J. Bury	ress / daugh	ter Rout	e 1 Box	425 - Ride	elev. We	st Virgini	a 26753
te Hear G	100	20a. Method of Disposition	gess / daugn	20b. Place of Dispo cemetery, crei	sition (Name of	125		20c. Location - City or	
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Dearli. Departitimporti		A 1. 4 P	alland			ur Street		•	21502
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OT VICAL RECORDS, P.O. BOX 08/0U, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the buriat-transit	Completed by Physiclan/Med	Partity Other significant condition	s pnthibuting to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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Phys this	2	1 ☐ Yes 2 No 27 Manner of Death	1 ∐ Inpatien 28a. Date of Injury	t 2 ER/Outpatier	IL 3 L DOA	4 Nursing Ho	me 5 ∐ Reside 28d. Describe ho	nce 6 Other (Spec	eity)
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Attending r death.	cat	2 Accident investiga 3 Suicide 6 Could no	t be Go Bless of Injur	ry - At home, farm, str			28f. Location /Str	reet and Number or Ru	ral Route Number.
UNISION OF VIKAL RECORDS, to Attending Physician: The law requires tarter death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	ij	4 Homicide determin	building, etc.	(Specify)	ost, ractory, omos		City or Town		,
DIVISION OT VITAL HER To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical Certification:	(Check only 2 Medical E	Physician: To the best of caminer: On the basis of c	examination and/or in					
the It in 24 the F	led	one)	and manner stat						
To To Con	2	29b. Signature and title of certifier	LP		29c. Licens	_	29	d. Date signed (Montl	n, Day, Tear)
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43		30. Name and address of person w	( )			Pood C	mhow1 a = 4	I. MD 2150	12
		Vimala A.  31. Date filed (Month, Day, Year)	Radjithan,		Oldrown	Road, Cu	mberrano	19 FID 213	, _
S Regis	tate	31. Date filed (Month, Day, Year)		o organication	Acres &				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 27, 2006 **Physician** 2:14 P M E11a Tulin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Days Hours Min. (Month, Day, Year) 09/15/1930 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕅 F Washington, DC 577-36-0142 75 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "naturel", or items 23s or 28e-f show any injury or other traumatic svent. The Movical Examinational be rectified at any injury or other traumatic svent. The Movical Examinational be rectified at any other. 10a, State 10b. County MD 1 Yes X No Montgomery Bethesda Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8031 Park Lane United States Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) artist sculptor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SHMUEL "SIDNEY" WALLITZKY BELLA TEPLITZKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NICHOLAS MOSEY/HUSBAND 8031 PARK LANE, BETHESDA, MARYLAND 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date National Crematorium 02/09/2006 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) intracerebral hemorrhage **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and deed betached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by atrial fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No this certificate has 2 No 1 Yes 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ₺ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Yes 2 No 2 Accident 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5. W.1KS D0063195 February 9, 2006 Bethesda, MD 20814 Wilks, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 15 2006 Registra

Amend item#23aPII,25 pen/E,686,61/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 10:59AM **Physician** February 27 - Ac. County of Death Paek Hyang Wood /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month Day Year) 8/5/1943 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Korea 62 049-64-3050 Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Aberdeen MD Harford Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or 404 Pine Street 21001 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 25 Married Specify: Korean 1 ☐ Yes ※ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 I Hygiene. other than "r College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygient Important: if Item 27 is marked other that any injury or other traumatic according. Homemaker In home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Chae Pong Han Hyang Ye Choe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Pine Street, Aberdeen, Maryland 21001 Dean L. Wood (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 2/27/06 Baker Cemetery Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kuska Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician O day 740C /Medical Due to (or as a consequence of): CENTIFICATION APPROVED BY NEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physicien and detached for use as the burial-trar Due to (or as a consequence of): Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 autopsy performed certificate has 2 No abuse 1 Yes oloacco funeral director, 25. Was case referred to medical examiner?
1 🔼 Yes 22 No 26. Place of Death Check only one Certification: To Be Hospital: 1 Nnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D0053568 February 24, 2006 person with completed cause of death (Item 23a) (Type, Print) HOMPSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 2 2006 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:30 AM February 8, 2006 James Dale Wilburn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3505 Old Trail Road Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. iast birthday) **Funeral** 1X M 2□F 25, 1943 Tennessee Director 413-72-5430 Oct. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28e-f show the Medical Exertings round be notified at 1 ☐ Yes 2 X No Directo Edgewater Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 United States or ftems 23a 3505 Old Trail Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Ki Yes 2 □ No 196;

If Xes, Give Year or Dates: 198; 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1962-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced 1982 "neturei", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed permit. Pages 1 and 2 shouid be filed wir Department of Health and Mental Hygien Important: if item 27 is marked other the eny injury or other treumatic event. the Custodial 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Eva Mae Atkins Ira Eugene Wilburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) 3505 Old Trail Road Edgewater, Maryland 21037 Juanita Anne Wilburn / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsville Vet. Cem. 2/14/2006 Crownsville, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home. Inc. 21. Signature of Funeral Service License Mile 147 Duke of Gloucester St. Annapolis, MD 2140 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final Mont **Physician** Due to (or as a consequence ol): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certifica funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print BROADWAY BALTIMORE, MO 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 5 Registrar 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 13,2006 3:28pm Bernard I. Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 88 May 4, 1917 215-38-7628 Maryland Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits wode rthen "natural", or items 23s or 28s-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Pasadena MD Anne Arundel 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 301 Green Drive 21122 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1⊠Yes 2 □ No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White à 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Coast Guard Military 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 1s marked oth any injury or other traumatic event, 90cs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Williams Mary Howsner 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD 21122 Alex Williams/Son 301 Green Drive Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State February 17, 1 XBurial 2 Cremation 3 Removal from State Crownsville, MD 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) defuce two Physician O Corau /Medical Due to (or as a consequence of): Examiner Cor onou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attanding physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown The law requires that the signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Mellitus Diabetes cate has been sig . page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes Division of Vital Physician: Be ( 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ▼ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Ž⊠No 3 DOA Medical Certification: To this 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 ⊠Natural 5 Pending Injury after death. 1 Yes 2 No investigation 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funarai C completely filled i 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50470 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pasadena High way, TLURI 8109 31. Date filed (Month, Day, Year) 32. Restrar's Signature State Registrar

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				State of Marylai	•		of Death	Wichtaning	Reg. No.	6 063	78
	Physici /Medic		1. Decedent's Name (First, Middle, La KENNとTH	WOODY				2. Date of De Month	Day 6 2	Year 00 6 /0:25	
)	Examir		4a. Facility Name (If not institution, giv BEVERLEY HE	-2				RICK	_ ′	DERICK	•
	Funeral Director		377 IE 1313	ex		If Under 1 Y Months Da	ear If Under 24 Hr. ays Hours Mir	8. Date of Bi	1920	9. Birthplace (State of Country) Washington	r Foreign
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince		ity, Town or Lo lelphi	cation				10d. Inside Cit	-
	h with the 23a or 28a	Funeral Director	10e. Street end Number 9200 Edwards Way	/ #204		10f. Zip Coo			10g. Citizen of United	What Country? States	
0200	filed within 72 hours efter death with the Maryland Hygiene. ther than enatural, or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 194 1 12/Yes 2 No If Yes, Give Year or Dates:			of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or Norto Rican, etc.)	Bia	ce - American Indian, ck, White, etc. Ican Americ	an
0-01713	within 72 ho ene. than *natura the Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)		lent's Usual Oo kind of work do DO NOT use re tal Cle	ccupetion one during most of wo stired)	orking	16b. Kind of B	usiness/Industry  Post Office	
ומוום	0 = 0 >	o Be Co	17. Father's Name (First, Middle, Last)  James Woody			-		<sub>ame (First, Middle</sub> Lee Book		ne)	
, Mary	and 2 should and No. 27 Is man		19a. Informant's Name/Relationship ( Linda Taylor (	(daughter)	1060	Oak Gr	reet and Number or F ove Road				
allillore	permit. Pages 1 and 2 should b Depertment of Health and Menta Importent: if item 27 Is marked any Injuryor other traumatic e once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Dispo cemetery, cren ryland	natory or other Nation	rplace) 1a T	Date 2/14/06	Laure	City or Town, State  Maryland	
משור	permit. Depertr Importe any Inji		21. Signature of Funeral Service Life		61	Name and Ad ARY L. O WE	ddress of Facility  ROLLINS  Sr SOURT	FUNCRAST FREE	L Home DERICR	mo 2170	) /
	Physician /Medical Examiner	ı,	23a. Part1. Enter the disease, o com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Late  Due to (c	th. Do not ente	er the mode of	dying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Betw Onset and D	e ween
, ,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death. within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	i Examiner	Sequentially list conditions, if ony, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b. Certonay  Due y (c	or as e conseq	uence g):	disea	ne.			
700 Y	certificate t nding physionse as the t	n/Medical	that initiated events resulting in death) Last	Due to (c	or as a consequ	uence of):					
	death	Physiclan/	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	nderlying cause	e given in Part I.	23b. Did	tobacco use co	ntribute to the cause o	of deeth?
	s thet the ned by the e detech	by Phy	Dementio					1 🗆	Yes 2□ No	3 □ Probably 4 🖼 🤇	Unknow
מנים מי	aw requires thet the death ce as been signed by the attendi 2 should be deteched for use	Completed b				~~~		24a. Was	en autopsy ormed?	24b. Were autopsy fin available prior to completion of ca of death?	0
<u> </u>	: The l							10		1 □ Yes 2 1 1	No
<u> </u>	sicien c certifi lirecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA	0.1	eath <i>(Check only o</i> Home 5 ☐ Resi		er (Specify)	
5	To the Hospital or Attending Physicien: The law within 24 burus effer death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 on the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director dir	ation: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. I	Injury at Work? 1 □ Yes 2 □ No	1	how injury occur		
	tal or Atters of the setter de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre fy)	eet, factory, off	ice	28f. Location ( City or To	Street and Numb wn, State)	per or Rural Route Numb	oer,
	he Hospi in 24 hou he Funer pletely fil	edical	29a. Certifier 1 ☑ CertifyIng Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or inv	estigation, in n	ny opinion, death occ	e, and due to the urred at the time,	date and place,	and due to the cause(s)	)
	To t	Σ	29b. Signature and title of certifier	MD.		29c. Lio	cense number	210	29d. Date signe	d (Month, Day, Year)	2
1	0		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, I	Print)	1	500	SV 11	N 21701	,
en .	Sta	te	31. Date liled (Month, Day, Year)	e Signatural Signatura Signatural Signatural Signatural Signatural Signatural Signatura Sig	ature /	xitcla	ire Hue	heder	ich M	0 21101	
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Registrar

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar	State of Man	/land / Dep		nt of H	ealth a				106	06380
\$	Dhusisi	Æ	1. Decedent's Name (First, Middle, Last)							Date of Death     Month	Day	Year	3. Time of Death
	Physici /Medi		Leo Walton Wagner							February	23,	, 2006	8:12 P M
ı	Examir	ier	4a. Facility Name (If not institution, give s	· ·				Location of				ounty of Death	
		Ja <sup>†</sup> t	28785 Three Notch		and the state of the		chani	csvil			St	. Mary	
N.	Funeral Director		5. Social Security Number 6. Sex 150 Usual Residence of Decedent	M 2□F	n yrs. last birthday, 64 Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day, 1 Oct 23, 1			place (State or Foreign ntry) Ington, D.C.
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow he Medical Exerciner must be positived at		10a. State 10b. County	10	oc. City, Town or L	ocation							10d. Inside City Limits
	Mar Mar	tor	Maryland St. Mary	's	Mechani	icsvi	11e						1 Tyes 2X No
	or 28	by Funeral Director	10e. Street and Number				p Code			10	g. Citizer	n of What Cou	ntry?
	15 will 15 wil	ai	28785 Three Notch	Road			2065	9			1	USA	
	ems erms	Iner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Dece	dent of Hi	spanic Orig	in? (Spec	rfy Yes or No- ican, etc.)	14.	Race - Ameri Black, White,	
9	or it	ΥF	1 ☐ Never Married 2 🛣 Married	1 ∐ Yes 2. ⚠ No If Yes, Give		1 ☐ Yes		Specify:			St	pecify: Whi	
ë	hours ural'	d b	3 Widowed 4 Divorced	Year or Dates:	100 0000		-10	A:					
5	n 72 "nai	iete	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece (Give	kind of wi DO NOT i	iai Occupa ork done d ise retired	ition luring most ( )	of working	g 11	SD. Kind	of Business/Ir	idustry
7	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		struc					Self	Employ	ved.
פַ	Hygie other	Be C	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle, Ma			
<u> a</u>	uld be Aenta rked tic ev	To B	Bosco Walton Wagn	er				Anna	Mae	Carr			
Maryland 21215-0036	and h		19a. Informant's Name/Relationship (Typ	оө, Print)	19b. Maili	ng Addres	s (Street a	nd Number	or Rural	Route Number,	City or To	own, State, Zij	Code)
	and and in 27 n 27 ner tr		Pauline Julia Wag					lotch		Mechani			
ore	Pages 1 nent of H ant: if iter ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re		20b. Place of Dispo cemetery, cre	nsition (Na matory or	me of other place	9)	Da	_		tion - City or T	
Ē	Pag tmen tant:		4 □ Donation 5 □ Other (Specify)		Fort Linco					, 2006 H	Brent	twood,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: if item 27 ie marked other then "natural", or items 23e or 28s-1 ehow emportant: if item 27 ie marked other then "natural", or items 23e or 28s-1 ehow emportant: or other treumatic event, the Medical Examiner must be confined as once.		21. Signature of Funeral Service License	fardiner		Matt P.O.	ingley Box 2	270, Le	ner F	uneral Hom town, MD 2	20650	.A.	
	Physician		23a. Part / Enter the disease, or compile shock, or heart failure. List only of Immediate Cause (Final disease or condition		RON PRY						st,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):		-	1					
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<del>ဂ</del>	w require s been sig should b	iete	HIPFRLIPIT	DEMIA						24a. Was an	2	4b. Were auto	opsy findings available
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ā	hysician: The la his certificate has I director, page 2	Be C	25. Was case referred to medical					26. Place	of Death	1 Yes 2 (Check only one)	No	10 105	2   140
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0	iding Phy th. After thi funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f	28c. Injury Work	at ?	28	d. Describe how	injury o	ccurred	
<u> </u>	endir eath. or: Al	Satic	2 Accident investigation			М	1 🗆 1	′es 2 □ N	0				
Division of Vital Records,	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica tely filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, st Specify)	reet, factor	y, office		28	3f. Location (Stre City or Town,	et and N State)	lumber or Rur	al Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	edical	29a Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	ician: To the bast of ware. On the basis of example and manner stated	amination and/or in	h occurred vestigation	at the time, in my op	a, date and inion, death	place ar occurred	d due to the cau d at the time, dat	ec(s) un e and pla	d marker at t ace, and due t	tated. o the cause(s)
	To the I within 2. To the I	Σ	29b. Signature and title of contitier			29	c. License	number	•			igned (Month,	Day, Year)
•			- Chilly som				17	777	,		1/2	4/06	
			30. Name and address of person who cor	•		,	. 1 77 - 4	1	MD C	2626			
	Sta	to	Anil K. Shah, M.D., F 31 Date filed (Month, Day, Year)	32: agistrar's	Signature	•		. Tywood	MD 20	0636			
	Registr	100	FEB 2 4 201	06	K A	and .							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Man	•	rtment of H			giene Reg. No. 006	06381
. 2	9	gi.	Decedent's Name (First, Middle, Last	)				2. Date of De		3. Time of Death
	Physici		Roy	Pau1	Vous	ngblood		Month	Day Ye	10 2327 M
i	/Medic Examir		4a. Facility Name (If not institution, give		100		Location of Death		4c. County of D	eath
*	Funeral		SACIPECI NEAR  5. Social Security Number 6. Se		ryrs. last birthday)	Cumber 1 Year	CRLANC If Under 24 Hrs.	8. Date of Birt (Month, Da	Alle G	Birthplace (State or Foreign Country)
	Director		219-14-7296	M 2□F	80 Yrs.	Months Days	Hours Min.	01/18/		arvland
	D		Usual Residence of Decedent							
	how		10a. State 10b. County	10	c. City, Town or Loc	ation				10d. Inside City Limits
	Ma -1-	Director	MD Allega	any	Cres	saptown				1 ☐ Yes 2 ☐ No
	r 28	ire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	3a 0	ā	14606 Oakwoo	nd Street		21	1502		USA	
	me 2	Funerai	11. Maritat Status	12. Was Decedent Eve	r in U.S. 13. W	as Decedent of Hi	ispanic Origin? (Si	pecify Yes or No	- 14. Race - A	merican tndian,
36	ges 1 and 2 should be tiled within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow or other treumatic event, the Mudical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ∑ Yes 2 ☐ No If Yes, Give Year or Dates:	1945-	Yes, specify Cubai □ Yes 2∑ No	n, Mexican, Puerti Specify:	Hican, etc.)	Specify:	/hite, etc. White
ŏ	2 hou	ed	15. Decedent's Edu	cation	16a. Decede	ent's Usual Occupa	ation		16b. Kind of Busine	
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Baltimore, Maryland 21215-0036	Aental rked o	To Be	Thomas	Y	oungblood		Ida		11e	Grimes
ar)	should and Men amarke umatic		19a. Informant's Name/Relationship (T	rpe, Print)	19b. Mailing	Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town, Stat	e, Zip Code)
Σ	and 2 Balth a n 27 to		Diane Comer / da	aughter	12411	McMuller	n Highway	, Cumbe	rland, MD	21502
อ์	s 1 an f Heal item 2 other		20a. Method of Disposition		20b. Place of Dispos			Date	20c. Location - City	
Ę	age ento nt:#		1XXBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation _ 5 ☐ Other (Specify,				1	3/2006	Cumberla	nd MD
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Ba	permit. Pages 1 and Department of Heali important: if item 2 eny injury or other once.		* Kebut C.	adam	40	04 Decati	ır Street	, Cumbe	rland, MD	21502
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ta	itical	O	25. Was case referred to medical				26. Place of Dea	1 Yes		165 20 140
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Division of Vital Records,	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	- At home, farm, stre Specify)	et, factory, office		28f. Location (S City or Tox	Street and Number of wn, State)	Rural Route Number,
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	⊢≯⊬ŏ		· The	6-		Doo	33280		Feb9	
	( fire)		30. Name and address of perion who c	ompleted cause of death	n (Item 23a) (Type, F	1			1,	
3	10		DR. SUNIL GU	32, Regisar's	35 Kent		ve, Cu	mberl	and M	0. 21502
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			1 - For State Registrar	State of Maryla		epartme Certifica			Mental Hy	ygiene Reg. No	1 4 4 6	06382		
	81.		1. Decedent's Name (First, Middle, Last)				-		2. Date of D		y Year,	3. Time of Death		
	Physici /Medio		Randall Lynn Alt						103	02	2006	7.50 AM		
	Examir Funeral	ner	4a Facility Name (If not institution, give s	treet and number)  Tr. Age (In yr.  M 2 F 53		day) If Und	ter 1 Year	If Under 24 Hrs Hours Min.	8. Date of B	idh	Scounty of Deat	murlum hplace (State or Foreign untry)		
	Director		214 54 7252 1 National Residence of Decedent	23	Yr	s.			Aug.10	) <b>,</b> 195	2 Wes	t Virginia		
	yland		10a. State 10b. County	10c. C	City, Town o	or Location						10d. Inside City Limits		
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5	or 28	Oire	10e. Street and Number			10f. 2	Zip Code				tizen of What Co	ountry?		
Muk	eth w	ra	422 Virginia Avenue				212				USA			
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show sayl hjurry or other traumatic event, the Modical Examinational be muitted at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Was Decedent Ever in Armed Forces?     I ⊠Yes 2 □ No If Yes, Give Year or Dates:	U.S.	If Yes, s	cedent of Hoecify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	10-	14. Race - Ame Black, Whit Specify: Wh			
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Hour yland 2	should be filed nd Mental Hyg marked other imatic event, i	To Be C	17. Father's Name (First, Middle, Last)  Ira C. Alt					18. Mother's Nar Elaine		le, Maider	n Surname)			
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CT E	Pages nent of int: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Mi		crematory o Bapti			6/2006	West	Keyse:			
Baltime	permit. I Depertm Importal sny Inju			Mineral Baptist Cemetery 3/6/2006 West Virginia  21. Signature of Funeral Service Ucensee    Down W. Durkouske   22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 2122										
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Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm	s, street, fact	ory, office		28f. Location City or To	(Street ai	nd Number or Ru e)	ural Route Number,		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (	(Check only 2 Medical Examin	ician: To the best of my ki er: On the basis of examinand manner stated.	nowledge, on nation and/o	or investigati	on, in my o	pinion, death occu	e, and due to the urred at the time	, date an	d place, and due	to the cause(s)		
	To To	2	29b. Signature and title of certifier			2	29c. License	e number		29d. Da	ate signed (Monta	h. Day, Year)		
	i		111000	WD		_	DOC	17624	(c)	3-	2-2	2006		
	1511		30 Name and address of person who con 31. Date filed (Month, Day, Year)	npleted cause of death (Ite 2.50) M 32. Registrar's Sign	7	pe. Print)	Fran	Klin Squ	are Dri	VE	Batto.	MI) 21237		
	Sta Registr		BIOD - CO	2 Nogonal V Sign	to A	P . af		,						

State of Maryland / Department of Health and Mental Hygiene For PHT C852 3/03/108/10/10 Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20<u>06</u> March **Physician** 1, Justine A. Ambrose 6:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 817 Camp Meade Road Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | (Month, Day, Year) | March 26, 1907 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F 172-14-1542 98 Austria Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23e or 28a-f show 1 ☐ Yes 2 X No Funeral Director Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8688 Doves Fly Way 20723 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White other treumatic event, It's Mudical Example Be Completed by lf Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) be Mathew Zebert Josephine Kastelic 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health au Important: If item 27 Is eny injury or other treu once. Alan R. Ambrose 8688 Doves Fly Way, Laurel, MD (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 X Removal from State Jefferson Mem'l Park 3/4/2006 Pittsburgh, PA ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of June al Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DN6657/15 T15 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** YORLVULA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit TREMPOSITI 725 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖼 No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by EMENTIA 1 Yes 2 No 3 Probably 4 Shinknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an certificate has 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: Certification: To 1 ☐ Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) Hospice this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D52255 MARCK MO 1, 7006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT MAGGIN 13852 BOUTIMONE ANE, CARREL, MARRICAND 20707 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

			For State Registrar			d / Depa		lealth and N	Mental Hygi	ene	06384	
48		s 36.	Decedent's Name (First, Middle,	Last)					2. Date of Death	3.110.	3. Time of Death	
	Physic		KATHLEEN	12 1100	NOLD				Month 02	Day Year	8.55 PM	
1	/Medi Exami						4b. City. Town.	or Location of Death		4c. County of Dea	Fl	
	LAdiliii	ici	4a. Facility Name (If not institution, MNNESSITY OF MUYEY) 22 SOUTH GREENE ST	and medica	LIENTER		BALTIMO			N/A		
	Funeral	- CB		6. Sex	7. Age (In yrs.	iast birthday)	If Under 1 Year		8. Date of Birth	9 Bir	thplace (State or Foreign	
	Director		220-64-3709	1 □ M 2 🖾 F	49	Yrs.	Months Days	Hours Min.	Oct. 15	1956 Mar	yland	
, C.:			Usual Residence of Decedent				I		, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	J	
	ylan		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits	
	Ma a-f-	to	Maryland N/A		Ba1	timore	<u>!</u>				1 ĀYes 2 □ No	
	r 28	irec	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	ountry?	
	h witi	O I	1123 West Lomba	ard Stree	t		2122	3		USA		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show to Modical Exeminant ke notified at	by Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame		
G	or ite	E	1 ☐ Never Married 2√ Marrie	Armed Fo	2 <b>∑</b> No	ł			Rican, etc.)	Black, Whi		
03	al', c	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D		1 ☐ Yes 2 ☐ No Specify:				Specify: Wh	iite	
21215-0036	2 ho	Completed	15. Decedent			16a. Dece	dent's Usual Occu	pation	16b. Kind of Busin		/Industry	
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21	filed within Hygiene.  Other than ent, ir e M	no:	10		,	Home	emaker			Own Home		
	othe	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	e (First, Middle, M.	aiden Sumame)		
a	fenta fenta rked rice	ToE	Robert	Vilfred		Glant	z	Margar	et El:	izabeth	Lantz	
Maryland	shou and N	-	19a. Informant's Name/Relationsh	p (Type, Print)						City or Town, State,	Zip Code)	
	nd 2 lith a 27 is		Tracy L. Rill (	Daughter)		103 F	Ridge Ave	., Taneyt	own, MD	21787		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens, important: If item 27 is marked other than "natural; or items 23a or 28a-f show important: If item 27 is marked other than "natural; or items 23a or 28a-f show yite into the fraumatic event, it a Medical Examination required at once.		20a. Method of Disposition			lace of Dispo	sition (Name of		Date 2	Oc. Location - City or	Town, State	
no	ages ant of t: if i		1 Burial 2 Cremation 4 Donation 5 Other (Sp		State		matory`or other pla ark Cemet		/06 Ba	altimore,	Maryland	
∄	it. P		21. Signature of Funeral Service L		шоц					k Funeral		
Ba	Depa Impo eny i		2 Olganicate of Fiducial Collision	Collidge			1620 W11k	ens Ave	Baltimo:	re, MD 212	229	
			22a Part Enter the disease or	ampliantians that	accord that doesn't						Approximate	
	Physician /Medical Examiner		23a. Part. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_ a	SEPSIS (or as a consequ	uence of):					Interval Between Onset and Death	
		-	Sequentially list conditions,	b. Due to	OF as a consequence							
	led Isit	i	Sequentially list conditions, any least 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events			and the same						
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	that led b deta	P	Part II. Other significant condition	s contributing to d	eath but not resi	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	o the cause of death?	
Records,	sign d be	d by	Haratitis C				_		1 ☐ Yes	2 <b>3</b> √No 3 □ Pi	robably 4 Unknown	
Ö	w requir been s should	Completed								- 1		
3e	e fav has	E E							24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
<u></u>	cate ha										2 □ No	
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Ha serianti			1 0		h (Check only one			
of	hysi this c	유	1 ☐ Yes 2 No	Hospital:		ER/Outpatier	nt 3 DOA	1er: 4 ☐ Nursing Ho	ome 5 🗆 Residen	ice 6 Other (Spe	ocify)	
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Divi	ital or Att rs after d al Direct sed in by	Certifi	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred								ural Route Number,	
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	To t To t	Σ	29b. Signature and title of certifier				29c. Licens	se number	290	d. Date signed (Mont	th, Day, Year)	
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				State of Maryland / Department of Health and M	Mental Hygier	ne O O O C	00000
			o-	1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)	Reg. I	<b>6.</b> UUD	3. Time of Death
4		Physici /Media		Lula Baynard	February.	26,2006	550p M
	-T1	Examir	ner	4a. Facility Name (If not institution, give street and number); Ab-City, Town, or Location of Death Maryland Greneral Hispital East mure	Coty	4c. County of Deat	A
	9	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Age (In yrs. last birthday) Annual Polys Hours Min.	8. Date of Birth Month, Day, Yea	31) 9. Birti	hplace (State or Foreign untry)  EDTG10
		ahow	ž	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 □ No
		ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic event, the Medical Examinar must be motified at	Director	Maryland NA Baltimore 10e. Sirbet and Number 10f. Zip Code	10g. (	Citizen of What Co	/-
		ne 23e	Funeral [	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. III Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,
Z	36	hours after of tural', or item		Armed Forces?  1 Never Married 2 Married   Armed Forces?   Il Yes, specify Cuban, Mexican, Puerto   1 Never Married 2 Married   Married	Rican, etc.)	Specify: D	
ara	5-0036	72 hou "natura	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	16b.	Kind of Business/	Industry
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Q	land	id be filed ental Hygi kad other ic event, I	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's Nam  ROVI	e (First, Middle, Maid	en Sumame)	, , ,
a	Mary	12 should and Mer is marks	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	al Route Number, City	y or Town, State, 2	Zip Code)
3		es 1 and 3 of Health if item 27 or other tra		20a. Method of Disposition  20b. Place of Disposition (Name of commetery, crematory or other place)	Date 20c.	Salto J Location - City or	VID 21215 Town, State
7	Baltimore	rtmer rtant riury		1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Ligensee	2006 D	undal	K, Md.
	Ba	Depa impo any is		Joseph L. Kuss Joseph Likuss	Funeral e. Raito	Home, Ma. Zizi	PA.
_		Dhusisian		23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death
		Physician /Medical Examiner		disease or condition resulting in death)  a. (DY/G/ST7 W/F W/T W/T W/T W/T W/T W/T W/T W/T W/T W/T			
			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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		within 2 To the comple	Medi	one) and manner stated.  29b. Signature and title of certifier 29c. License number		Date signed (Month	
-					/	, ,	
	-	2		30. and address of person who completed cause of death (Item 23a) (Types, Print)  AND MORATER M. ().	Gener	al Mi	Spitop
		Sta Registr		31. Date liled (Month, Day, Year)  32. Registrar's Signature		, , ,	

		1 - For State Registrar		State of Ma	ryland /		rtment of h		Mental F	lygiene Reg. No	11110	06386	
Physi /Mec		1. Decedent's Name (First	2	Brow	NW		the City Town		2. Date of Month	Death Da		3. Time of Death 7:15 P	
Funera Directo	1	4a. Facility Name (If het in MC res Number 5. Social Security Number 220 - 52	1 edic	A/ Ce	ute (In yrs. last	birthday)_ Yrs.	4b. City, Town, o	If Under 24 Hi	rs. 8. Date of Month,	/	Salt 9. Bir	TMUNS thplace (State or Forei puntry) ARVLAN	ign
e Maryland	ctor	Usual Residence of Deceding 10a. State 10b.	ent County	4	10c. City, To	own or Loc	0	THORE		7/		10d. Inside City Limi 1 ⊠ Yes 2 □ N	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tall Hygiene.  nd other then "natural", or Iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number  1909  11. Marital Status  1 Never Married 2		2. Was Decedent Armed Forces?  1   Yes 2   M	ver in U.S.	13. W	10f. Zip Code  Vas Decedent of H Yes, specify Cuba	2/2 lispanic Origin? an, Mexican, Pue Specify:			14. Race - Ame Black, Whit	4; erican Indian,	
21215-0036 d within 72 hours af giene. or then "natural, or the Medical Exam	Completed by		ecedent's Educa highest grade	Year or Dates: ation		6a. Decede (Give k life. D	ent's Usual Occup and of work done O NOT use retired	nation during most of w	vorking		Specify: B	LACK  Industry  LIAL SERVICE	FC
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- 6 6 6		A LFREDA  20a. Method of Disposition  18 Burial 2 Crem	BROW nation 3 Re	N CWI	PE)	190 e of Dispos etery, crem	9 E. O. ition (Name of atory or other place	LIVER	ST. B.	4LTO 200. L	ocation - City or	2/2/3 Town, State	3_
Baltimore permit. Pages 1 Department of He Important: If iten		21. Signature of Funeral S	Service Licensee	1. Wil	lean	22.	140 N	ss of Pacility	BROW.	BA	NSDOWI R. FUN LTO, MD	NE MARVIA VERAL HO 21217 Approximate	ME
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S Regis	tate trar	31. Date filed (Month, Day		13	ar's Signature	9	sel.					-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 230 Year **Physician** 28, rebruary 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Maryland General LAMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Socurity Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 42-6415 M 2□ F Yrs. 6 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f abov other traumatic event, the Medical Examinar must be reditived at Baltimore Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Black Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONGT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Hygiane Sumame) Mother's Name (First, Middle, Maide ather's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ead Deraid ine City or Town, State, Zip Code; Informant's Name/Relationship (Type, 19b. Mailing Address (Stree a Number or Rural Route Number, 21213 20b. Place of Disposition (Name of cemet, ry, crematory groths) Department of Health a Importent: if Item 27 is any injury or other tra more Date 20c. Location 20a. Method of Disposition City or Town, State 1 Burial 2 Cremation
4 Donation 5 Qther (S 3 ☐Removal from State ation 5 Other (Specify) dellatoron MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory F Failure **Physician** disease or condition resulting in death) /Medical Examiner Chronic obstructive Rulmonum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical the attending | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day 5 Other (specify) 4 Pregnant at time of death signed by the a Id be detached f ☐Yes 2☐No o 9 Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown leted peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Comple page 2 s has autopsy performed certificate 2 No 2 No 1 Yes 1 ☐ Yes of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Division 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: completely filled in by the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Direct 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Menth, Day, Year) 2 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) AYNE SII BBARNEY WD

State Registrar

DHMH 17 Rev 1/2001

32 Registrar's Signature

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,			1. Decedent's Name (First, Middle, Last)	)			3.8 (	2. Date of De Month	ath Day	3. Time of Death	
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ы	Funeral		5. Social Security Number 6. Sex	TM OVIE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Da	v, Year)	<ol> <li>Birthplace (State or Foreign Country)</li> </ol>	ın
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21215-0036	within 72 hours after deeth with the Maryland ene. Itan "natural", or itema 23a or 28a-f ehow ha Madical Exeminer must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of v	working	16b. Kind of Bu	siness/Industry	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importanent of Health and Mental Hygiene. Integrate it is marked at the how any injury or other traumatic event, the Madical Examination and be notified at once.		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other place	- I	Date	20c. Location - 0	City or Town, State	
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DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	-	eartment of Health ertificate of Death			ene g. No. 0 0	5 06390
H	Physicia	an	1. Decedent's Name (First, Middle, La		ECKER			Date of Death Month ERRUAR	Day	Year 2.006 4.50 P M
	/Medic Examin		4LICE  4a. Facility Name (If not institution, give		01-01-0	4b. City, Town, or Location		CORUM	4c. County of	f Death
	Examin	eı		HOSPITAL		RANDALLST	-	)	BAC	TIMORE
	Funeral Director		5. Social Security Number 6. 9 081-38-5859	Sex 7. Age 1  M 2	61 Yrs.	If Under 1 Year   If Under 1 Months   Days   Hours	Min. M	Date of Birth Month, Day, IAR 13	1944	9. Birthplace (State or Foreign Country) NY
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Maryi:	to	MD Baltimon	re ·	Pikesvil	le				1 ☐ Yes 2X No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	
	23a	ral	802 Smoke Tree I		Tues in II C 12	21208	risin2 (Coopi	f. Van er Ne		SA - American Indian,
9	after de or Item miner n	Funeral	11. Marital Status 1 X Never Married 2  Married	12. Was Decedent I Armed Forces? 1Yes 2 X		. Was Decedent of Hispanic O If Yes, specify Cuban, Mexico 1 ☐ Yes 2 ☒ No Specify	an, Puerto Ric	can, etc.)	Black	, White, etc.
003	urel', o	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	10.0		y.		Specify:	MITTE
15	n nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual Occupation e kind of work done during mo DO NOT use retired)	st of working	7	6b. Kind of Bus	iness/industry
212	giene.	Com	Elementary/Secondary (0-12)	College (1-4or 5	Comp	uter Analyst			Comput	
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other then "naturel", or freme 23a or 28e-1 show eumatic event, the Madical Examinar must be notified at	To Be (	17. Father's Name (First, Middle, Last Benjamin Josep		•		her's Name (i Simone		aiden Sumame rry	)
Mary	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic a <u>once</u> .		19a. Informant's Name/Relationship (Robert Becker - 1			ling Address (Street and Number 2 Lofty Lane,				
ore,	of Heal		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 [	TRomoval from State	20b. Place of Disp cemetery, cr	position (Name of ematory or other place)	Dat	te 2	Oc. Location - C	City or Town, State
Ĭ	permit. Pages Department of I Important: If its eny injury or or once.		4 □ Donation 5 □ Other (Speci	fy)		ke Crematory				11e, MD
Bai	Departiment of the permit of t		21. Signature of Funeral Service Lice	nsee	M00986	CAFA, Stephen 8717 Green Pas	"D. Lol stures	hrmann, Drive,	PA Towson	, MD 21286
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each lin	10.			respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	PULA	a consequence of):	EMBOLISI	<u> </u>			
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8760,	ficate be executed physicien and is the burial-transit	dical		_ d						
Box 6	death certific attending pl	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_			23d. Date	of delivery
P.O. B(	ne death the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 4∏Pregnant at 9∭Unknown		☐ Ectopic pregnancy ☐ Other (specify)			Mont	th Day Year
	res thet the de igned by the a be deteched t	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause given in Par	t I.	23e. Did tob	acco use contril	bute to the cause of death?
Sign	w require been sig should b	ted b	SEPSIS					1 □ Ye	s 2□No <	3 Probably 4 Qunknown
Division of Vital Records,	8 C	Completed						24a. Was an autopsy perform 1 XYes 2	ed?   de	ere autopsy findings available ior to completion of cause of eath?
ā	len: ]	BeC	25. Was case referred to medical examiner?			26. Pla	ce of Death (	Check only one		2103 2210
<u>ح</u>	Physic this ce al dire	မ	1AYes 2□ No	Hospital: 1 X Inpatie					nce 6 Other	
o o	Attending Physiclen: or death. ector: Atter this certifice by the funeral director.	tlon	27. Manner of Death  1 XNatural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury			d. Describe no	w injury occurre	u
)ivisi	5 분 등 드	Certification:	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Inj	ury - At home, farm, : c. (Specify)	street, factory, office	28	Bf. Location (Str City or Town		r or Rural Route Number,
_	To the Hospital within 24 hours a vithin 24 hours a completely filled		29a. Certifier 12 Certifying P	hysician: To the best	of my knowledge, de	ath occurred at the time, date a	and place, an	nd due to the ca	use(s) and man	ner as stated.
	the Ho nin 24 the Fu	<b>ledical</b>	one)	and manner sta	t examination and/or ated.	investigation, in my opinion, de				
	5 1× 5 00	Σ	29b. Signature and late of certifier			29c. License numbe			•	(Month, Day, Year)
7	67	9	30. Name and address of person who		M · P leath (Item 23a) (Typ	e, Print)	E-	i-l	SOKUARY	22 2006
	ン		LEONARD RICHARDSO	N 5401 OL	D COURT RO		TOWN,	MPZ	21133	<i>M</i>
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 3 20		ar's Signature	needs.	,			
				The state of the same	- Jul 1893	TAL TOTAL				

Sonia Briskman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#8, perfil, 6833.3/3/06 tT 06-1465 AKG Unpend item#231,25 at Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death February 27, **Physician** РМ SONIA 2006 BRISKMAN 5:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner University Hospital
5. Social Security Number 6. Sex Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth 2/14/1930. Birthplace (State or Foreign (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 ☐ F 212-26-0327 75 Yrs. 12/04/1930 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ? Is marked other than "natural" or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified as 1 ☐ Yes 2 ☑ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 POMONA WEST APT. #12 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 W No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked off **JACK** KITT **ROSE** GOLDFEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANA GOLDSMITH / NIECE CEDARMERE CIRCLE - OWINGS MILLS, MD 21117 other 20b. Place of Disposition (Name of cametery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ŏ permit. Page Department of Important: If any Injury or once. MARYLAND VETERANS 03/02/2006 OWINGS MILLS, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. leve 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple injuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit the attending physicien and hed for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) à page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \( \subseteq \) No 24a. Was an certificete hes autopsy performed? 1 Yes 2 □ No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To XXYes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu Fnd 2/27/2006 М investigation 1 ☐ Yes 2X Xo 2 Accident unk unk 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 5 Pomona West #12 4 Homicide House Pikesville, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lile & O.C.M.E. March 1, 2006

State Registrar

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland, 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

32. Registrar's Signature

RUBIO

MAR 0 3 2006

MA 31. Date filed (Month, Day, Year)

			Chate of Maniford / Department of Health and A		9
			State of Maryland / Department of Health and N  1- State Registrar Certificate of Death	vientai Hygi	ene 2006 06392
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	g. Nb. 3. Time of Death
	Physici			Month	Day Year 23:58 M
	/Medio Examir		4a Facility Name //f not institution, give street and number) 4b. City Town or Location of Death		4c. County of Death
	LXXIIII		BALTIMORE/WASHINGTON CENTER GLEN BURNIE	€	ANNE ARUNDEL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 05/08/1	Year)  9. Birthplace (State or Foreign Country)
	Director		212-28-7661 1 M 2 F 75 Yrs. Months Days Hours Min.	05/08/1	930 MARÝLAND
	yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	A-f sh	ctor	MD ANNE ARUNDEL GLEN BURNIE		XXyes 2 □ No
	or 28	Oire	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	477 LINCOLN DRIVE 21060	anaita Van an Na	14. Race - American Indian,
	ter de	-une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
036	urs af	ρ	If Yes, Give 1 ☐ Yes 2 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: BLACK
2.0	72 hours naturel', dical Exe	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	kina 1	6b. Kind of Business/Industry
20RY	vithin ne. han	Completed	Elementary/Secondary (0·12) College (1·4or5+) CLERICAL	Ü	JS CENSUS BUREAU
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one Z	id be ental ked o	To Be		ETTA GOO	DD
ary ary	shou and M and M	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru		
<sub>O</sub> ≥	and 2 salth a		VANESSA Y. CARY/DAUGHTER 477 LINCOLN DR, GI	-	
Je Syl Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inportants of Health and Mental Hygiene. Importants of Health and Mental Hygiene. In marked other than "naturel; or liems 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition  XD Burial 2 Cremation 3 Removal from State  ARBUTUS MEM. PK. 3/7		Oc. Location - City or Town, State  BALTIMORE CO., MD
10) =	it. Par rtmen rtant: njury		4 Donation 5 Dotner (Specify)		
Ba (	Derm Depa Impo eny i				JNERAL HOME 21207 VE., BALTIMORE, MD
	_		23a. Part Enter the disease, or complications that caused the death. Dynot enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition a MYOCARDINE TWEE		Unserand Death
	/Medical		resulting in death)  Due to (or as a consequence of):	10000	0.02 1.00
	Examiner	_	Sequentially list conditions,		
	ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
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760.	te be exe ysicien a re burial-	cai	d		
.89	ruffica ng ph as th	Physician/Medi	IF FEMALE:		
6 g	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
5.5%	the a	ysici	1   Yes   20   No   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown		Month Day Tour
~ 0	hat deta	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ic sp	quires n sign ald be	d by	CEREBROUNSLUUNR ACYDENT	i X Yes	2 No 3 Probably 4 Unknown
S-SL S. S. Of Vital Records.	as bee	Completed	PERIPHERAL VASCULAR DISEASC	24a. Was an	
^ <u>~</u>	The lav ate has page 2	mo:	HYPERTENSION	autopsy performe	ed? death? 1 \( \text{Yes} \) 2 \( \text{No} \) No
/ita	Attending Physician: Th r death. sotor; Atter this certificate by the funeral director, pag	Be (	examiner?	th Check only one	
29 0	Physi this c	_T		ome 5 Residen	nce 6 Other (Specify)
ر - e	Jing After fune	tlon	27. Manner of Death  Natural 5 Pending  Proceeding investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Nork?  1 Yes 2 No	28d. Describe nov	v injury occurred
ر-حرا Division	Attendi	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	eet and Number or Rural Route Number,
ق ق	s afte	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town,	State)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier  (CHOCK ONLY  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the cau	use(s) and manner as stated. te and place, and due to the cause(s)
	thin 24 the f	Medical	and manner stated.	,	
	Z W T		D00400	12 1	MARCH 2, 2006
	7 1	Fig	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 (47)	VILLS MA DIAGE
	2		29b. Signature and title of certifier  29c. License number	1, 44 01	1501 CE   110 0100C
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	-	
	Registr	ar			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year February 24, 2006 **Physician** 8:00 A M Terry E. Clements /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care - Bethesda Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🂢 F 213-82-0238 57 North Carolina Director Mar. 27, 1948 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "netural", or Items 23e or 28a-f ehow empty injury or other traumatic event, it is Medical Examinar must be retilled an once. 1 ☐ Yes 2X No Director Maryland Howard Laurel 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 9200 Montpelier Drive 20906 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 [Yes 2 2No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 4No Specify: þ White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ralph Clements Jessie Inez Whitaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pamela J. Bussom / Sister 1 Bodon Ct., Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 27 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Pk. 2006 Glen Burnie, Maryland 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 21. Signature of Funcial Sen et License M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HSpiration Physician days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physicien and ned for use as the burial-tran Division of Vital Records, P.O. Box 68760, X Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 menths? Year Month Day 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Winknown Completed has been Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Att completely filled in by the fun 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 🔀 Curtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated 29a Carrier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 29c. License number Physicies D0055694 February 24,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Olsey- Leytonsville Rd Obey, HD 20832 ALOK MATITUIZ 31. Date filed (Month, Day, Year) 32 Segistrar's Signature State MAR 0 3 2006 Registrar

Cassada claiberre with the Maryland اکگہ کے حرکیہ ا Maryland 21215-0036 KIRNA Baltimore,

1 - For State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Year Cassandra Michelle Claiborne 2006 Febuary チブ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City
If Under 1 Year If Under 24 Hrs. N/ASinai hospital 0 Batimore . Age (In yrs. last birthday) 55 Yrs. 8. Date of Birth (Month, Day, Year) Jan, 18, 1951 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min 216-58-0307 1 ☐ M 2 🖫 F Director MDUsual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits show rither 73s or 28e-f shov MD N/ABaltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6618 Eberle Drive apt #104 21215 USA Completed by Funeral 2 should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ★ Married 5 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced "natural" 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) Nurse Assistant Nursing Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Jones is marked Amielier Carter 2 19a. Informant's Name/Relationship (*Type, Print*) ${ t Husband}_{\mathbb{R}}$  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6618 Eberle Drive apt. #104 Baltimore Md. Daniel R. Claiborne Jr. Health tem 27 Itam 27 other t 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h
Important: If Ite
eny injury or ot
once. King Memorial Park 3/03/06 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signatur of uneral Servi icensee 5240 Reisterstown Rd Baltimore Md. 21215 Alexis 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Distress disease or condition resulting in death) HOUTE /Medical Due to (or as a consequence of): Examiner Sarcoidosis 1 teal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the buriat-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23b. Was decedent preggant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signe should be c Completed by 1 Yes 2 No 3 Probably 4 Horrown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? 1 Yes 2 1 No or Attending Physician: 25. Was case referred to edical director Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☐ No 1 patient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident the To the Hospital or Atten within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ompletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Fy way 22/ 2006 Nec-000 Name and addre death (Item 23a) (Type, Print) Hospital of Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem 5 per fh 9853 3-17-06 vt.
State of Maryland 7 Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amend item#17-perfit, 335,3/13/06 Tr State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:22 AM February 28 Cheatham 2006 Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H-3pital Baltimare City of Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Days Hours Min Yrs. 72 33 Director 231-40-8269 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-1 show traumstic event, the Medical Examinar must be notified at †XTYes 2 ☐ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 6807 Westridge Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married XX Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Steel Worker Beth Steel Corp. 8th grade na 17. Father's Name (First, Middle, Last)
William
Cillian C. Cheatham 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be a and Mental Savannah May Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 21207 Lorentha Cheatham-Wife 6807 Westridge Road, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of ! permit. Pages Department of Important: If it any injury or o once. Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 3/4/06 Druid Ridge Pikesville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West alo 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebra /Medical Due to (or as a consequence of) Examiner OAGULD PATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine rsicien and e burial-transit certificate be execu resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical phys use as the ed by the attending I detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Thrombosis 1 ☐ Yes 2 ☑ No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 4 pertensian 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To ð this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending To the hosping within 24 hours after death.

To the Funerel Director: Aft investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and http of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) emuter trancis 31. Date filed (Month, Day, Year) 32 Pedistrar's Signature State MAR 03 2006 Registrar

DHMH 17 Rev 1/2001

Cheatham

1 - For State Registrar

10a. State

**Physician** 

/Medical

Examiner

**Funeral** 

Director

A =

1. Decedent's Name (First, Middle, Last)

SINN HOSPITAL

5. Social Security Number

197-14-9119

Usual Residence of Decedent

Mary Jane Conlon

10b. County

4a. Facility Name (If not institution, give street and number)

OF

1 ☐ M 2 🕱 F

6. Sex

BALTIMORE

7. Age (In yrs. last birthday)

10c. City, Town or Location

81

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MENT	Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei	1	20b. Plac	ce of Disposition (inetery, crematory)	Name of or other place)	Dat	9 200	. Location - City or	Town, State
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J	alt	permit. Depart Import eny inj once.		21. Signature of Funeral Service Licensee	. 0		22. Name	and Address of Fa	icility Hub	bard Fun	eral Home	e. Inc.
		20E39		July C	mo						ore, Mar	yland 21229
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	Vital Records, P.O. Box 68760,	sician: The law requires that the death certificate be executed certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of 1 Live birth 2 [			pregnancy			23d. Date of de	livery
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	- H	rsician: The law s certificate has t director, page 2 s	Con							performed 1 ☐ Yes 2 ☑	death?	212/No
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	Division of	9 # 5 ⊆	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	Specify)	e, farm, street, fac	ory, office	281	City or Town, Si	and inumber of Hi ate)	ural Route Number,
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		24 h	Medical	(Check only 2 Medical Examine one)	er: On the basis of ex	amınatıo	n and/or investigat	on, in my opinion,	death occurred	at the time, date	and place, and due	to the cause(s)
		To the within 2 To the complex	Me	29b. Signature and title of certifier			T	29c. License numb	өг	29d.	Date signed (Mont	h, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

BALTIMORE

HUSPITAL OF

BAJIMORE

4b. City, Town, or Location of Death

2. Date of Death Month

City

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year)

FEBRUARY

Jan 1, 1925

3. Time of Death

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

Pennsylvania

0915 M

Year

2006

A

4c. County of Death

24

State

Registrar

ALYSSA

31. Date filed (Month, Day, Year)

LETTICH

MAR 0 3 2006

Registrar's Signature

06-01361 dl

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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death with the Maryland me 23a or 28a-f ahow	OMBE		8513 Aspen Crest			1	95624				USA			
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do							<b>c</b> , 011	Approximate Interval Between	
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ָּטָ יָּ		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence	of):								
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ate be ex hysician		<u>m</u>		Due to (or as a co	nisequence	01):								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funere Director: After this certificate has been signed by the attending physician and more partial traces of the physician and the dependent of the physician and the dependent of the physician and the p	9 3	dicai		d										
h certii	200	Physician/me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy						23d	. Date of delive	nv.	
death death		Cla	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time			Ectopic pregnancy Other (specify)				200	Month	Day Year	
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s the		y y	Part II. Other significant conditions of	ontributing to death but no	ot resulting	in the un	derlying cause give	en in Part I.		23e. Did tob	acco use	contribute to th	e cause of death	?
require Ben sig										1 🗌 Ye	s 2 🗆 N	lo 3 ☐ Prob	ably 4 Onkno	nwc
as be	2	bie								24a. Was an		4b. Were auto	osy findings availa	able
The The	Page 1	Сотріете								perform		death?	2□ No	OI.
clan:	200	9	25. Was case referred to medical examiner?					26. Place	of Death (C	heck only one	)			
Physic this c		<u> </u>	1 ☑ Yes 2 ☐ No	Hospital:			3□ DOA Othe	4 LI Nurs				Other (Specify	2	
Jing I		Certification	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye		Time of Injury	28c. Injury Work	at ? ∕es 2.7N		Describe ho	w injury o	coursed by	ight.	
Utten deatl ctor:		2	2 Accident investigation 3 Suicide 6 Could not b	1 0	At home, f	arm stre	JTMW44	193 2/4/1	28f	Location (Str	eet and N	lumber or Rura	Route Number,	
affer of the		e	4 Homicide determined	building, etc. (S	ipecify)	or l	ot, factory, office		1	City or Town	State)	Ver Duy	Roadty	1
spits hours nerel		<u> </u>	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of m	v knowleda	e. death	occurred at the tim	e, date and	place, and	due to the ca	use(s) an	d manner as st	ated.	-9
To the Hospital or Attending Physician: The lav Within 24 hours after death. To the Funcest Director After this certificate has promoted the find to but the funcard director page.		edical	(Check only 2 Medical Exert one)	niner: On the basis of exa and manner stated.	ımination aı	nd/or inve	estigation, in my op	oinion, death	n occurred a	t the time, da	te and pla	ace, and due to	the cause(s)	
Vithii To th			29b. Signature and title of certifier				29c. License	number		29	d. Date s	igned (Month,	Day, Year)	
1			Theoder Il	Link -	ews		OCME				Fehr	ary 24	2006	
100			30. Name and address of person who		(Item 23a)	(Type, P						J 67		
¥			HEODOREM. Kung				111 Penn	Stre	et, Ba	altimo	re, N	Marylano	1 21201	
Rec	State Stra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature									
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DHMH 17 Rev 1/2001

ORIGINAL

			1- For State of Mai		artment of I		d Mental Hyg	giene 30g. No. 0 0 6	06398
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
	/Media	cal	Ira E. Chaffman				March		
7	Examir	ner	4a. Facility Name (If not institution, give street and number)  Westminster Nursing Ho	.m.c	4b. City, Town, o	or Location of D minste		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 I			
н	Director		YOYM ACTE	36 Yrs.	Months Days	Hours N	Feb. 2	9. Bi 1, 1920 Ma	inthplace (State or Foreign Country)
	pu >		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo					
	shoved at all	7	MD Carroll		sburg				10d. Inside City Limits 1 ☐ Yes ※ X No
	28e-f	ect	10e. Street and Number	FIIIX	10f. Zip Code			10g. Citizen of What C	
	3a or	۵	2538 Old Kays Mill Rd.	•		1048		U.S.A	
	death	nera	11 Marital Status 12 Was Decedent Fy	verin (IS 13.)			? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am	
98	or Ite	E/	Amed Forces?  1 Never Married 2 Married  Amed Forces?  Amed Forces?  Amed Forces?	)	i Tes, specify Cub 1 □ Yes 🏋 🏋 No		uerto Rican, etc.)		
5-0036	72 hours after death with the Maryland naturel; or items 23a or 28e-f show diest Executed must be positived at	d b	XXWidowed 4 Divorced If Yes, Give Year or Dates: W						White
215-	in 72	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occuj kind of work done DO NOT use retire	pation during most of ed)	working	16b. Kind of Busines:	s/Industry
212	d with piene. r thar	шо	Elementary/Secondary (0-12) College (1-4or 5+)	)	ections		1	State o	f Maryland
	e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	Maiden Surname)	
<u>ylaı</u>	should be find Mental B marked of umetic eve	70	Raymond Chaffman				a A. Ric		
Maryland	2 shd n and ts m reum		19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State,	
-	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or Items 23a or 28e-f show any njury or other treumetic event, the Madical Exercities matike notified at once.		Daniel C. Chaffman / Son  20a. Method of Disposition	E. Control	_			csburg, M	
Baltimore	ages nt of J t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cametery, cren EVERG 1t Memor	ratory or other pla	ісе)	4 . 40 -		
Ħ	it. Partme		4 □ Donation ★ Other (Specify Entomer 21. Signature → Fureral Solvice License	Memor 22	ial Gard	dens 3	/4/06	Finksbu Funeral H	
Ba	Depo Impo any		I hickord lawn						11s,MD21117
İ	Pnysician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one caus an each line Immediate Cause (Final	he death. Do not ent	er the mode of dyi	ing, such as care	diac or respiratory arr		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  Due to (or as a	consequence of):	and I	,	In Dr.		1000-
		-	Sequentially list conditions, if any leading to immediate Due to (or as a	consequence of):	roter b	asen	m Ner	Hasi	23/
1	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	work	l aa	4			,
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9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:						
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rds	quires n sigr ald be	d by					1 □ Y	es 2. <del>2No</del> 3.∏P	robably 4 DUnknown
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	The lav	E O					— autops perfor 1 ☐ Yes	med? death?	
Vital		Be C	25. Was case referred to medical examiner?			26. Place of	Death (Check only or		
of V	Physicien: this certific ral director,	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatien	I 3 DOA		ng Home 5 Resid	ence 6 Other (Spe	ecity)
	ding Ph. After thi funeral	on:	27. Manner of Death 28a. Date of Injury 1 ☑Natural 5 ☐ Pending (Month, Day)	Year) 28b. Time of Injury	Wo		28d. Describe h	ow injury occurred	
isic	r Attending er death. rector: After by the fune:	Icat	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Injury	y - At home, farm, stre		Yes 2 □ No	28f Location (S	treet and Number or F	Pural Pouto Number
Division	o it e	Certification;	4 Homicide determined building, etc.	(Specify)	eet, ractory, office		City or Town		dural noble Number,
	spite nours nerel		29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death	occurred at the ti	me, date and pl	lace, and due to the c	ause(s) and manner a	is stated.
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of e	xamination and/or inv	vestigation, in my	opinion, death o	occurred at the time, d	late and place, and du	e to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier		29c. Licens	se number	2	29d. Date signed (Mon	ith, Day, Year)
	Ø		I alm moldhow		02	544	3	3/1/2006	e
	Y		30. Name and address of person who completed cause of dea	th (Item 23a) (Type,	1 0	, , 1	1.1.	1 4	
	,		31. Date filed (Month, Day, Year) & Registrar	s Signature	ole K	and l	Nishmy	ster MI	1211)
•	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 3 2006	s Signature	de la	_		•	

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 26, 2006 **Physician** JOHN 10:40 PM Μ. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE-WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL Months Days Hours Min. REB. 3, Year 58 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 212-76-8737 1 □XM 2 □ F MARYLAND 48 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "naturel", or iteme 23a or 28e-f ehow the Modical Exeminar must be notified at HANOVER 1 ☐ Yes 2X No MARYLAND ANNE ARUNDEL Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 150 CHESAPEAKE MBL CT. 21076 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24540 If Yes, Give 24 Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or item eny injury or other treumatic event, the Madical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2√√No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ELECTRICAL SPLICER TRENCHING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY E. MANNING JOHN DYSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 SYMPHONY WAY, CENTREVILLE, MARYLAND 21617 JOHN DYSON / FATHER 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Dination 5 ☐ Other (Specify) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MARCH 2, GLEN HAVEN MEM. PK. GLEN BURNIE, MARYLAND 2005 of Funeral Service 21. Signat densee KIRKLEY ARUDDICKY FUNERAL HOME, P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai ettending pt for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 20 NO 1 Yes 2 NO 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 24 hor To the Fune completely fi 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year)
MAR 0 3 20 32. Registrar's Signature State 2006 Registrar

			1 - For State Registrar	State of Mar		l / Depa		of He	alth a				06	06400
	Dhusis		1. Decedent's Name (First, Middle, Las	1)						2	. Date of Death Month	Day	Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give			i	4b. City, 7	Town, or L	ocation of	f Death		4c. Cou	inty of Death	
₹b.			555 S. Atwood Roa					Air				1	rford	
	Funeral Director		5. Social Security Number 6. Sec. 219–28–7460	7. Age (		st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, ug. 29,	Year) 1923	9. Birthp Coun New	lace (State or Foreign itry) Jersey
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	r 28a	Director	10e. Street and Number	Id			10f. Zip				10	g. Citizen	of What Coun	ntry?
	A with	Ö	555 S. Atwood Roa	d, Apt. 21	1			210	14			U.	S.A.	
	death	Funerai	11. Marital Status	12. Was Decedent Ev		. 13. V	Was Deced	ent of Hist	panic Orig	in? (Specif	y Yes or No- can, etc.)		Race - Americ	
٥	after or its		1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 ₹☐ No		4	1 ☐ Yes 2	***	Specify:	, Fuerto Rit	Jan, 8(C.)		Black, White, o ecity: whi	
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2	should nd Men marka umatic	ဥ	19a. Informant's Name/Relationship (7	vna Print)		19h Mailin	na Address	(Street an			Route Number,	City or To	um State Zin	Code
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တ်	ss 1 and 2 should of Health and Mer item 27 is marks other traumatic		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nam	e of	1	Dat	e 2	Oc. Location	on - City or To	wn, State
Baitimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify			легегу, сгел Josep				3/4/2	006	Ralti	lmore,	Md.
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	ding Phys	ı.	27. Manner of Death	28a. Date of Injury (Month, Day Y	2	8b. Time of Injury		c. Injury a Work?			d. Describe hov			<i>'</i>
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DIVISION	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At hom (Specify)	e, farm, stre	eet, factory,	office		28f	Location (Street)		mber or Rural	Route Number,
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				A			D	37	612		A	lasi	41	2006
	12		30. Name and address of person who co	ompleted cause of deat	th (Item 2	.3a) (Type, I		0 1				· vu		
	1		Mohamad Alabr	ash, M.D.,	1601	l S. I	ollga	te R	d., I	Bel A:	ir, MD	21015		
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		Funeral Director		5. Social Security Number 219-03-7522	6. Sex 1X M 2 ☐ F	7. Age (In y	rs. last birtho 34 Yrs	Month	er 1 Year s Days			irth Day, Yea <i>r)</i> 1 <b>,</b> 192	1 Mar	thplace (State or Foreign buntry)  yland
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		d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or itama 23s or 28s-f show traumatic event, the Mcdital Examiner must be mutilled.	I Director	10e. Street and Number 1315 Willow (	Chase Driv	e e		1 Of. 2	ip Code 2101	5		10g. Citi	zen of What Co USA	puntry?
Z		death	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in	U.S.	13. Was Dec	edent of I	Hispanic Origin? (S an, Mexican, Pue	Specify Yes or N	lo-	14. Race - Ame	
8	36	72 hours after death w 'natural', or Itama 23a d'eal Exeminer deat	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	ried 1 Yes	2 🗌 No /e			еспу Сив 2 <mark>У</mark> Д No		no rican, etc.)		Specify: White	
+	5-0036	2 hou	ted	15. Deceder	nt's Education	4103.	16a. De	ecedent's Us	ual Occu	pation		16b. Ki	nd of Business	findustry
5534	2	ithin 7	Completed	(Specify only night Elementary/Secondary (0-12)	st grade completed) Coltege (1	1-4or 5+)				during most of wo	orking			
(2)	21	filed with Hygiene other tha	Con	11			Cal	binet	Make				inet Ma	king
$\bigcirc$	and	be fill Hall Hall He off	Be	17. Father's Name (First, Middle, August (unk)	Dembeck					18. Mother's Na Marth	me (First, Middl a <b>(u</b> nk)		<sub>Sumame)</sub> upski	
	Ž	2 should be filed wand Mental Hygie I amarked other traumatic event, In	ဥ	19a. Informant's Name/Relations			10b M	lailia- Adda	an /Ctrant	and Number or R				Tin Control
٩	, Maryland	c = 01 L		Brian B. Dembe			131	5 Will	.ow C	hase Dri	ve, Bel	Air,	Maryla	nd 21015
90	Baltimore,	of of		20a. Method of Disposition		State	. Place of Di cemetery. iklawn	crematory`or	other pla		Date / 2006		cation - City or	Town, State Maryland
~	altir	permit. Pag Department Important: I any Injury c	1	21. Signatur of Fund al Service		1				2020 2021 Table	cComas I		<u> </u>	<del></del>
3	<u>—</u>	89 E 29		Muls a	may			1317 C	okes	bury Roa	d, Abina	gdon,		
				23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on e	aused the de ach line.	eath. Do not	enter the mo	ode of dyl	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
		Pnysician /Medical		disease or condition resulting in death)	aCu	or as a cons	equence of);	rege	her	_				
20485700		Examiner		Sequentially list conditions.	b									
D	X	ed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its tool experts.)	Due to (	or as a cons	equence of):							
30	٦.	te be executed ysician and e burial-transit	xan	that initiated events resulting in death) Last	c. Due to (	or as a cons	equence of):							
8	760,	e be e /siclar e buri	g		L <sub>d</sub>								1	
8	9	tifficate ng phys as the	ledi		- V									
#	Вох	attending for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of preg		3 □Ectopic	oregnanc	v		2	3d. Date of del	,
Z	O. E	The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregna 9☐ Unkno	ant at time o		5 Other (s		,			Month	Day Year
rnard	٥.	that the post of t	by Ph	Part II. Other significant condition	ons contributing to de	ath but not r	esulting in th	e underlying	cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
3	cords,	w requires been signi should be	ed b	corone	arles	lye					1 🗆	Yes 2	No 3□Pr	obably 4 Nunknown
3	ဝ၁	law re as bee 2 sho	Completed	Muonie	ren l	Lul					24a. Wa		24b. Were au	topsy findings available
9	R	The Tate has page	mo.						-		auto perf	ormed?	death?	completion of cause of
1	Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medica examiner?						26. Place of De	ath (Check only	_		
5	of \	Physic this o	2	1 Yes 2 No		npatient 2				4   Nursing F	Home 5 Res	idence 6	Other (Spe	cify)
100	u C	ding Physician: n. After this certific funeral director.	lon	27. Manner of Death  1 Solution	9	of Injury h, Day Year)	28b. Timi Injur	e of ry M	28c. Injur Wor		28d. Describe	how injury	occurred	
5	Division	or Attend after death Director: A in by the f	flcat	2 Accident Investig	not be	of Injury - At	home farm			Yes 2 No	28f Location	(Street and	Number or Ri	ıral Route Number.
De n	Div	rs after al Dire	Certification:	4 Homicide determ	buildir	ng, etc. (Spe	cify)	3,,001, 140,0	19, 011100		City or To	wn, State)	, wanter or ric	irar riobte reuniber,
<u>( )</u>		To the Hospital or Attending Physician: within 24 hours after death.  To the Funaral Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifyir 2 Medical	ng Physician: To the Examiner: On the ba and mann	asis of exami	nowledge, de nation and/o	eath occurre r investigatio	d at the tir	me, date and place opinion, death occu	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
		To the within To the comp	Me	29b. Signature and title of certifie	-			29	c. Licens	se number		29d Date	signed (Monti	n, Day, Year)
		. 1		Dave	SDL				0	3 2297		Ma.	Sel.	200(
		1141		30. Name and address of person									,	
	405	71		31. Date filed (Month, Day, Year)	DUND 20.0	615	w. n	1 x c P	ha.	1 Bel	air m	2		
		Sta Registr		MAD 0 2	2006	6/5 egistrar's Sig	to do	anded						

		•	State of Marylan	d / Depa		lealth and M	lental Hygie	9	06402
Physici /Medio		1. Decedent's Name (First, Middle, Last)  Nancy E. Eck					2. Date of Death Month Feb. 20,		3. Time of Death 9:50 p M
Examir Funeral Director	ner	4a. Facility Name (If not institution, give street Paradise Ass. Living 5. Social Security Number 216-14-7181 6. Sex		last birthday) Yrs.	Catonsvi If Under 1 Year Months Days	11e If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, ) Oct 30,	4c. County of Death Baltimor  9. Birth 1922 MD 00	re
e Maryland 3e-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  MD Baltimore		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
th with th	al Dire	10e. Street and Number 6348 Frederick			10f. Zip Code 21228		100	g. Citizen of What Co USA	
72 hours after death with the Maryland natural', or Items 23e or 28e-f ehow deat Examinar must be notified at	by Funeral	11. Marital Status  The Never Married 2 Married  3 Widowed 4 Divorced	. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ANo	lispanic Origin? (Sp. an, Mexican, Puerto Specify: whi		14. Race - Amer Black, White Specify:	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Hygiene.  Department of Hygiene.  Department of Hygiene.  Department of Hygiene.	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of work	ing	Sb. Kind of Business/I	ndustry
could be filed Mental Hyg varked othe	To Be C	17. Father's Name (First, Middle, Last) Hary Carl Eck				Helen Ma	e (First, Middle, Ma arie Mitc	hell	
s 1 and 2 sh of Health and item 27 ie m other traum		19a. Informant's Name/Relationship (Type Murry Adams - Neph 20a. Method of Disposition	1ew 20b. P	3028		n Circle	Ellicott	City or Town, State, Z  City MD  Oc. Location - City or 1	21043
Dermit. Pages Department of Importent: If it any Injury or o		1 Deurial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) 21. Signature Funeral Service Censee	Lot	idon Pa		ery Feb. 2		altimore C k Funeral	
Physician		23a. Part. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that out ed the death cause order h line.					e. MD 2122	Approximate Interval Between Onset and Death
Medical  Examiner  Asician and  be prival-transit	cal Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cheen are on injury that initiated events resulting in death) Last  d.	Due to fr as a consequence to (or as a consequence to (or as a consequence)	uence of):					
sicien: The law requires that the death certificate certificate has been signed by the attending phys rector, page 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deli	very Day Year
The law requires that the law seques should be detache	by	Part II. Other significant conditions contri	buting to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
i: The law re cate has bee	Completed						24a. Was an autopsy performe	prior to c death?	topsy findings available completion of cause of
Phys this	atlon; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 Inpatient 2 (28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing Ho	n (Check only one) me 5 KResiden 28d. Describe how	ce 6 Other (Specinity) occurred	ify)
To the Hospitel or Attending within 24 hours after death of To the Funerel Director. After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	<i>'</i> )			City or Town,		
o the Hosp lithin 24 holo the Fune empletely fi	Medical	29a. Certifier Certifying Physic (Check only one)  29b. Signature and title of certifier	ian: To the best of my knor: On the basis of examina and manner stated.	wiedge, deatl tion and/or in	occurred at the tirvestigation, in my o			se(s) and manner as and place, and due	
F 3 F 8		Catriot W. h	pleted cause of death (Item	). 1 23a) (Type	023	3365			22, 200s MO 71828
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	05 5	ederte.	Rd.#2	02, Br	berivore,	BZSIS OM
Regist	rar	MAR 0 3 200	06	K A	and I				

DHMH 17 Rev 1/2001

NAQUY ECK

2/20/06 9:50 P. M.

ORIGINAL

			1 - For State Registrar	state of Marylan		artment of tificate of			giene	6 06403
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Fred A.	Eckman			-	2. Date of Dea Month March		3. Time of Death 5:22 p M
	Examir		4a. Facility Name (If not institution, give stre Charlestown Care C				n, or Location of De $\mathrm{Sville}$	ath	4c. County of Baltir	
	Funeral Director		5. Social Security Number 052-16-6236 6. Sex 1 🖾 M	7. Age (In yrs. 2☐ F	last birthday) 5 Yrs.	If Under 1 Ye Months Da			, Year)	. Birthplace (State or Foreign Country) NY
	Maryland a-f ehow	tor	10a. State 10b. County Baltimore		y, Town or Lo Catonsv					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	ath with the 23s or 28 ust be not	Funeral Director	10e. Street and Number 709 Maiden Choice	Lane		10f. Zip Cod 2:	1228		10g. Citizen ot Wha	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tiern 27 te marked other than "natural", or itema 28a or 28a-f ehow any injury or other traumatic event. The Medical Expresser must be notified at once.	þ	11. Maritat Status 12.  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U. Armed Forces? 1 (ՃYes 2 □ No If Yes, Give Year or Dates: WW]	1	Vas Decedent of Yes, specify C □ Yes 2 1	uban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Black,	American Indian, White, etc. White
21215-0036	within 72 ho lene. than "natu the Medical	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	on mpleted) Cotlege (1-4or 5+)	(Give	O NOT use rea	ne durina most of w	orking	16b. Kind of Busin	ness/Industry
Maryland 2	uld be filed Mental Hyg irked other ific event.	To Be C	17. Father's Name (First, Middle, Last)  John	Eckman	ricona	incar r		ame (First, Middle, d		
e, Mary	and 2 sho lealth and I m 27 te me her trauma		19a. Informant's Name/Relationship (Type, Michael Eckman - s	on	420	Kings (	College Da	Rural Route Number	old, MD	21012
Baltimore,	it. Pages 1 rtment of H rtant: If ita njury or ot		20a. Method of Disposition  1 □ Burial 2 ②Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)		esapeak	A TOTAL PROPERTY.	atory 3/.	3/2006	20c. Location · Cit Beltsvill	
Ba	Depa Impo any is		21. Significant of Funeral Sorvice License.  23a. Part. Enter the disease, or complication	MOOG	186   87	17 Gree	en Pasture	Lohrmann, es Drive,	Towson,	MD 21286 Approximate
الم	Physician /Medical		Immediate Cause (Final	ause on each line.	az ro		disea			Interval Between Onset and Death
	physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, b  b  b  b  b  b  b  cause. Enter Underlying  Cause (Disease or injury that indiated events resulting in death) Last  c  d.	Due to (or as a consequence to (or as a consequence)	renieu of):					
P.O. Box 6	nin say requires may the dean centric site has been signed by the attending pl bage 2 should be detached for use as i	Completed by Physician/Mec	in the past 12 months?	f yes, oufcome of pregna 1□Live birth 2□Fetel 4□Pregnant at time of de 9□Unknown	death 3 1	Ectopic pregnar Other (specify)			23d. Date of Month	delivery Day Year
rds, P	been signed t	ed by PI	Part II. Other significant conditions confrib	uting to death but nof resu	itting in the un	derlying cause	given in Part I.			te to the cause of death?  Probably 4 Unknown
		e Compiet	25. Was case referred to medicat						prior ned? deat	
DIVISION OF VI	this le	To B	examiner? 1 ☐ Yes 2. No Hosp	1   Inpatient 2   1	ER/Outpatient 28b. Time of Injury	28c. In	Other: Nursing	eath Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (	Specify)
DIVIS	within 24 hours after des To the Funerel Directo completely filled in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 2	Be. Ptace of Injury - At hos building, etc. (Specify,	)			City or Town	, State)	r Rural Route Number,
9	o the Fun	Medicai	(Oncome of the Care Examiner.	n: To the best of my know On the basis of examinati and manner stated.	vledge, death ion and/or inve	estigation, in my	time, date and place opinion, death occurrence	urred at the time, da	use(s) and manne ite and place, and od. Date signed (M	due to the cause(s)
, 1			30. Name and address of person who comple	ated cause of death (ttem	23a) (Tune D	D	30989		March 2,	
0	Star Registra		Dr. Myla Carpenter 31. Date tiled (Month, Day, Year) MAR 0.3.2006		aiden C	hoice I	ane, Cato	onsville,	MD 2122	8

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year February 26 2006 Physician 12:35p<sup>M</sup> Louise torbes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1□M 212F 12 Director O19-52-5036 Usual Residence of Decedent 6/24/33 Trinidad 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f ehow the Medical Examinar roust be notified at 10d. Inside City Limits 1 des 2 □ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 4007 21213 USA Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 Ø No 21215-003 Be Completed by Specify: Specify: 3 ☐ Widowed 4 ☐ vivorced Blac K 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) Haencies 12 NUrsing Assistant Hivate more, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any july or other traumatic event 9DBB. 18. Mother's Name (First, Middle, Maiden Surname) 2 Teixiera Benjamin Joseph ear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Forbes 4007 Ardley Avenue Novalene Baltimore MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arbutus memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 3/6/05 Baltimore 22. Name and Address of Facility
Joseph L. Russ F/H, P.A. 21. Signature of Funeral Service Licensee Jaze W Tatelle /farris W. North Avenue - Balto MO-21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MEGACOLO **Physician** /Medical Due to (or as a consequence of): Examiner Differ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed) certificate 100 1 Yes 2 🗷 No : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner. On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 31. Date filed (Month 32. Registrar's Signature State Registrar

		•	For Stata Registrar	State of M	aryland / Depa <i>Ce</i>	artment of l rtificate of		d Men		ene	96	06405
	Physici /Medic		1. Decedent's Name (First, Middle, La  BRANDON T. F					l N	Date of Death Month EB. 26	5 <sup>Day</sup> 200	) 6	3. Time of Death 4:40P
	Examir		4a. Facility Name (If not institution, giv 1515 SHADYSID	e street and number)	)		or Location of De				ty of Death	
<b>(</b>	Funeral Director		211 30 7010	ex 7. Ag	ge (In yrs. last birthday) 29 Yrs.	Il Under 1 Year Months Days		lin. (/	Date of Birth Month, Day, Y 2/28/	<sup>(ear)</sup> 1976	Cou	place (State or Foreig ntry) RYLAND
	r 28s-f show	tor	Usuel Residence of Decedent		10c. City, Town or Lo	cation TIMORE	CITY					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow crivet be notified at	Funeral Director	10e. Street and Number 1515 SHADDYSID	E ROAD		10f. Zip Code 212	18		100		What Cou	ntry?
036	hours after deat lure!, or items 2 al Exeminer mu	þ	11. Marital Status  X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces 1  Yes 2  If If Yes, Give Year or Dates:	? No	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 No	oan, Mexican, Pu	(Specify uerto Rica	Yes or No- n, etc.)	BI	ace - Ameri ack, White, ify: BLP	etc.
9500-61212	within 72 ane. then "nai	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of ed)	working		Sb. Kind of	Business/Ir BLED	dustry
land 2	be filed tal Hygi d other event, I	To Be Co	12TH 17. Father's Name (First, Middle, Last ERNEST FOSTER						st, Middle, Ma		ime)	
, mary	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (		OTHER 15	ng Address (Stree		E RD	, BAL	TIMOE	RE,MI	21218
altimore,	9 = 5	10.3	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Special	y)	ARBUTUS	MEM.P	K. 03	Date 3 / 0 3	-		ORE	CO., MD
g C	permit. Par Departmen Important: eny Injury once.		21. Signature of Funeral Service Lice	N. K	ww "	2. Name and Addr 1600 LI	BERTY 1				BAHP)	MoRE, MC
	Physician /Medical Examiner	J.	23a hant Enter the disease, or common shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as	gestive Nea s a consequence of): te renal fulls s a consequence of):	rt failur		diac or res	pratory arres			Approximate Interval Between Onset and Death  Month  Month
8760,	cate be executed physicien and the burial-transit	dicai Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Aor		ation						29 years
P.O. BOX 6	law requires that the death certific as been signed by the attending p 2 should be detached for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 Fetal death 3	Ectopic pregnand Other (specify)	су				ate of delive	ery Day Year
	w requires that been signed I should be det	<u>م</u>	Part II. Other significant conditions of Diabetes mellit		but not resulting in the u	nderlying cause g	iven in Part I.		23e. Did toba 1 🗌 Yes		ntribute to t	the cause of death?  bably 4 Unknown
Vital Records,	The ate h page	Completed	Deep venous H	isodnon	•			-	24a. Was an autopsy performe		were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
ō	£ ± 4	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ient 2 ER/Outpatier ury 28b. Time o Injury	f 28c. Inju	her: 4 🗆 Nursin	g Home	seck only one)  5 ★ Residen  Describe how			(y)
Division	itel or Atte	Certification:	3 Suicide 6 Could not be determined	286. Place of in	ijury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office			Location (Stre City or Town,		nber or Run	al Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director; After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 № Certifying Pl	nysician: To the best niner: On the basis of and manner st	t of my knowledge, deat of examination and/or in tated.	vestigation, in my	ime, date and pl opinion, death o se number	ace, and o	t the time, date	e and place	and due t	stated. o the cause(s)  Day, Year)
1	3		30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)	)-6260					2006
0	Sta		Eric Schmidt MD 18 31. Date liled (Month, Day, Year)	32. Regist	onument Streetrar's Signature	et Suite 9	020 Bal	hmore	e, Mary	land	2128	7
DHI	Regist	4-1	MAR 0 3	2006	CHAIR MA	for the		·				

			1 - For State Registrar		State o	f Mary	land				ealth a		ental Hy	giene	1116		05407	
П			Decedent's Name (First, Middle	e, Last)		-							2. Date of De	aath			3. Time of Death	_
	Physicia /Medic		Louis	Α.	Fr	itz,	M.D	).					March	2, 2	ž006 <sup>°°</sup>	ar	11:46 a M	Į.
)	Examin		4a. Facility Name (If not institution			nber)			4b. City	, Town, or	Location of	of Death		40	. County of E	eath		
			Gilchrist (							Towsc					Balt			
ı	Funeral Director		5. Social Security Number 219–22–7075	6. Sex	M 2□F	7. Age (In	79 79	Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Di Jan 2E	rth ay, Year, 3, 19	9.	Birthp Coun Mar	lace (State or Foreign try) yland	1
	and w		Usual Residence of Decedent  10a. State 10b. County			10	c. City,	Town or Lo	cation							1	0d. fnside City Limits	
	Maryl 1 ehc	P	MD Bal	timor	e			Phoe	nix								1 ☐ Yes 2 💢 No	1
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	death	Funerai	11. Marital Status	12	2. Was Dece	edent Ever	r in U.S.	. 13. \	Was Dec	edent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	0-	14. Race - A			
9	or its		1 ☐ Never Married 2 Mar	ried	1 X Yes If Yes, Giv	2 No	JUJ I	1		2⊠ No			nicari, etc.)		Black, V Specify:			
3	72 hours after death with the Maryla frature!, or iteme 23e or 28e1 ehov digal Examiner must be notified at	d by	3 Widowed 4 Divorced		Year or Da	ates:												
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7	withir Bne. then	Completed	Elementary/Secondary (0-12)		College (1	-4or 5+)   <del> </del>					ogis	t		*	Medic:	ine		
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2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or iteme 23e or 28e-f show aumstic event, the Madical Examinar must be notified at	To Be	Louis /	Adam	F	ritz					1	Franc	ces	C.	1	Lan	g	
a y	shor and N		19a. Informant's Name/Relations	hip (Type	, Print)			19b. Mailin	ng Addres	s (Street a	and Numbe	or Rura	l Route Numb	er, City	or Town, Star	te, Zip	Code)	
Ξ,	end 2		Rosemarie R. R	ritz	z–wife			37 W	linde	mere	Parkı	ыay,	Phoeni	.x, M	1D 211	131		
ב ה	of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 □ 🛭 🗈 🗷	moval from	04-4-	cerr	ce of Disponentery, crem	natory or	other place	θ)		ate		ocation - City			
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	parmit. Pages 1 and 2 should be filed within Department of Heelit and Mental Hygiene. Important: If item 27 is marked other then eny Injury or other traumatic event, the Magnes.		21. Signature of Funeral Service	Licensee	Willi	am G	. Da						ck Tows Json, M		unera: 21204	1 H	ome, Inc.	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complica	ations that c	aused the	death.	Do not ente	er the mo	de of dying	g, such as	cardiac o	r respiratory a	ırrest,			Approximate Interval Between	
Ţ	Physician		Immediate Cause (Final disease or condition			AS	PI	10	tio	M	on.	901	respiratory a	A		12	Onset and Death	
	/Medical		resulting in death)	( a.	Due to (	or as a co	nseque	nce of):		()	,		1 0					
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0	phys s the	dical		d.														
×.	certif ding ISB a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	230	c. If yes, out	come of p	regnanc	ey .							23d. Date of	delive	inv	
2	atter d for u	ciar	in the past 12 months?		1☐Live b	irth 2 🗀	Fetal de	eath 3	Ectopic (	pecify)					Month		Day Year	
į	the cathe	hysi	9 Unknown		9□ Unkno	own			· ·									
_	s that	by P	Part II. Other significant condition	ons contr	ibuting to de								23e. Did	tobacco	use contribut	te to th	e cause of death?	
5	equire an sig	ed It	multiple	<u>Str</u>	Vices	U/t	An	Sical	TIS	chon	nee		10	Yes 2	No 3	Prob	ably 4 □Unknown	
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=	ing P	ë ë	27. Manner of Death  1 ☑ Natural 5 ☐ Pendir	ng	28a. Date ( (Mont	of Injury th, Day Ye	ar) 2	8b. Time of Injury		28c. Injury Work			28d. Describe	how inju	ry occurred		0	
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2	or At	Certification;	4 Homicide determ			of fnjury - ng, etc. (5		ie, farm, str	eet, facto	ry, office		2	28f. Location ( City or To			r Rura.	l Route Number,	
-	pital ours e eral (	Ce	29a. Certifier Certifyin	na Physic	ian To 4-	hort of -	u kacud	odae dee"		t at the to	a date a	d place	and due to the		\ aad =		ated	_
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours eldeath. To the Euneral Director. Ther this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	<b>ledicai</b>	(Check only 2 Medical one)	Examine	r: On the ba	asis of exa ner stated.	amination	n and/or inv	vestigatio	n, in my op	oinion, dea	th occurre	and due to the	date an	d place, and	due to	the cause(s)	
	To To	Σ	29b. Signature and title of certifie	L	,	10	7	mo	29	c. License	number	٠.١.٠	_	29d. Da	te signed (M	fonth, i	Day, Year)	
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	6+1		30. Name and address of person	. (2	7	0/4	m		Print)	11	N. C	ho	les J	SK.	Fal	to	2006 .ms 212	0
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			1 - State	State of Maryta		ate of Death		2006	051.08
	*		Registrar  1. Decedent's Name (First, Middle, Last	1)	- Continue	ne or Death	2. Date of Death	No. 0 0 0	3. Time of Death
п	Physic		Judia S	+0110	Gre	o n	Month	Day Year 26.6	8:30 PM
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		y, Jown, or Location of Dea	tebruary	4c. County of Death	0 + 301
		N.	Northwest	Hospita	a(	Randalls	town	Balt	more
	Funeral		5. Social Security Number 6. Se	M 20 F	Month	ler 1 Year If Under 24 Hrs s Days Hours Min		9. Birthp	lace (State or Foreign
- 4	Director		218-76-3014	5	Yrs.		March 3	,1947 Ma	cryland
	land		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Location			1	0d. Inside City Limits
	Mary 1 eh	ţō	Maria Balt	1 no 4 1/2	Roade	iletain	Ω		1 Yes 2 No
	r 28a	rec	10e. Street and Number	1111012	1 and	Zip Code	10g	. Citizen of What Cour	ntry?
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	eme :	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	US. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ Black, White,	
36	or it	E V	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 □ Yes	/	110011, 010.7	Specify:	i i
21215-0036	72 hours after death with the Maryland naturel', or iteme 23a or 28a-f ehow disal Examiner must be notified at	Completed by Funeral Director	3 ☐ Widowed 4 🖫 Divorced  15. Decedent's Edu	Year or Dates:	160 Deceded to U		40	0	lack
15	in 72	olet	(Specify only highest grad	le completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of wo use retired)	orking	b. Kind of Business/Inc	dustry
212	jene. r then the Med	E	Elementary/Secondary (0-12)	College (1-4or 5+)	- 1	3abled		NIA	
	al Hyg othe	Bec	17. Father's Name (First, Middle, Last)				me (First, Middle, Ma.	den Sumame)	
/lai	uld b Ments prked	To	Leon Gre	en		Lu	edia.	w) right	
Maryland	2 should be filed within and Mental Hygiene. Ie marked other then reumatic event, the Mg		19a. Informant's Name/Relationship (T)	ype, Print) (Son)	19b. Mailing Addre	ss (Street and Number or R	ural Route Number, C	ity or Town, Sate, Zip	Code)
	and ealth m 27 her tr		Mr. Shawa C	unningham	16135	Honewood 1	Road Bal	timore, M	
0	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Disposition (A cometery, crematory of	r other place)	Date 200	. Location City or To	wn, State
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.		4 Donation 5 Other (Specify)		rinity Cem	etery 17/9	12006	Dundalk	, MD
Bal	permit. Departr tmports eny inju		21. Signature of Funeral Service Licens	P P	ose	ph he Rus	S, Funera	1 Hone,	PaAn
			23a. Part /Enter the disease, or compl	lications that coursed the de	ath Do not enter the m	W. North	AVENUE	balto,	MD 21216 Approximate
*	DI		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.		Carrying, social coldina	7	noma	Interval Between Onset and Death
0	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		0000000	2 001011	10111	YIX
	Examiner				equanica or).				
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P.O.	the d y the	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown	J J J J J J J J J J J J J J J J J J J	specify)			
σ.	es that the death cer igned by the attendin be detached for use		Part II. Other significant conditions con	ntributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
Records,	quire; in sig uld bi	Completed by	Alcohol Live	2 Cirrhen	n, ch	rome	1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
၀	aw requir s been s 2 should	plet	atual tib	ulation			24a. Was an	24b. Were auto	osy findings available
Ä	The lay	E O					autopsy performed	l? death?	npletion of cause of
Vital	ysicien: The lis certificate hadirector, page	Bec	25. Was case referred to medical examiner?			26. Place of De	ath [Check only one]	10 103	20110
of V	Physic this ce al dire	To	1 Yes 2 No	Hospital: 1 Impatient 2[	□ ER/Outpatient 3□ I	OOA Other: 4 Nursing F	Home 5 Residence	e 6 Other (Specify	')
u u	iding Phy th: After this	ë.	27. Manner of Death  1 □Nettural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	
sio	tend seath tor: A	cat	2 Accident Investigation 3 Suicide 6 Could not be		М	1 Yes 2 No			
Division	or Attendater death Director: in by the	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factority)	ory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	Route Number,
	purs a leral lilled		29a. Certifier 1 Cartifying Phys	sician: To the best of my kr	Sowlodge death seems	d at the time, data and place		./	
	24 h 24 h Fun etely	Medical	(Check only 2 Medical Exami	ner: On the basis of examinand manner stated.	nation and/or investigation	on, in my opinion, death occi	e, and due to the caus urred at the time, date	e(s) and manner as st and place, and due to	the cause(s)
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier		NA D 2	9c. License number		Date signed (Month, I	
	, 0		> Klange	oughin	コーリ	1)54285		eshus	my 8 2006
1	4		30. Name and address of person who co		em 23a) (Type Print)	1184285	NO+ 110	F 6 +	U, -t:
_			Ramarwaimy	I Range	a de jour	House	C31 110)	Julia Mi	anter
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature				
18,23	negistr	वा	MADAAAAA	Re .	10 11 40				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#8, perFH, C833, 3/3/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. UUA 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** ELIZABETH 8:38AM February 28 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, HOSPITAL Birthplace (State or Foreign Country) Funeral 5. Social Security Number 7. Age (In yrs. last birthday) 1 ■ M 2 XF 39-36-3353 Yrs. NORTH CAROLINA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1. Yes 2 □ No Director TIHORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? STREET or items 23e 800 5 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 ₩idowed 4 Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) HIGRADE PRIVATE 577C WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 is any injury or other tree once. 915 W. LEXINGTON SISTER ST. BALTO, MD. 21223 ELA GR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MT. CARMEL CEME 03-07-06 BALTIMORE, MI \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee BROWN JR. FUNERAL HOME ULTONAVE, BALTO, MD. 2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOLARD:AL TN FARCMON PROBAB2E hom disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC D13E15E 4NENOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 11 physicien and the burial-transit The law requires that the death certiticate be executed CARDIAL Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HYPERZIPE DEMPLA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed MALNUTRITION 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HYPERTENTION 2 1 No 1 Yes to the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 10 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide vithin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ompletely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) February 28 2006 D 23300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13 c N SECUMPS HUST PATEL ND, 2000W. SUDKIR, BALTO STO 1342TO MAD. 21223 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 0 3 2006 Registrar DESCRIPTION

		1 - For State Registrar		/ Department of Health and Certificate of Death		J. No.	06411
Physici	an	1. Decedent's Name (First, Middle, Las			2. Date of Death Month	Day Year	3. Time of Death
/Medic		ROBERT	GRE	66	FEBRUARY	28, 2006	1625 P
Examin	ner	4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or Location of De	ath	4c. County of Deat	h
	ш	NORTHNEST	HOSPITAL	RANDALLSTON		BALTO	MORE
uneral rector		5. Social Security Number 6. S. 218-26-6865 Usual Residence of Decedent	ex 7. Age (In yrs. lasi	Yrs. If Under 1 Year If Under 24 H Months Days Hours M		(ear) 9. Birt Co 1930 M	hplace (State or Forei untry) ARYLAND
MOM		10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Limi
- 1	tō	MARYLAND HARFO	RD CO	ABERDEEN			1 ☐ Yes 21⁄2 N
128 101	re	10e. Street and Number		10f. Zip Code	100	. Citizen of What Co	untry?
23a o	E C	653 ELM STREET		21001			,
e e	Je	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	U.S.A.	rican Indian.
Importent: If Item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other treumatic event. The Mudical Exprehent must be notified at size.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Put  1 ☐ Yes 2 No Specify:	erto Rican, etc.)	Black, White	e, etc.
n "natur Medical	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16	b. Kind of Business/	Industry
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ent.		17. Father's Name (First, Middle, Last)	0 120		ame (First, Middle, Ma		JN
D O	To Be	FRANK GREGG			EY FORESTE	,	
Tat	-	19a. Informant's Name/Relationship (7	Vpe Print)	9b. Mailing Address (Street and Number or I			"- O- d-)
27 is		Marlene Lehman/S					
tem other		20a. Method of Disposition	20b. Place	653 Elm Street, Aber of Disposition (Name of		Land 2100] c. Location - City or 1	
# 5 F 6	1	1 X Burial 2 Cremation 3	Removal from State ceme	otery, crematory or other place)	20	c. Location - City of	own, State
ing .	1	4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Lights	DEREC		06-06 D	ARLINGTON,	MARYLAND
n y i		21. Signature of Funerar Service Lizea:	500	22. Name and Address of Facility WM C BROWN COMM FU	NERAL HOME	-HARFORD	РΔ
- 0 0		Willem /	7	321 S PHILADELPHI	A BLVD AI	BERDEEN. M	1D 21001
sician		Immediate Cause (Final / disease or condition	one cause on each line.	to not enter the mode of dying, such as cardi	ac or respiratory arrest		Approximate Interval Between Onset and Death
dical		resulting in death)	Due to or as a consequence	ce of):			reigh
niner		Sequentially list conditions	b				
=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce of):			-
burial-transit	Examiner	that initiated events	c				
rial	Ä	resulting in death) Last	Due to (or as a consequence	pe of);			
	cai		d				
as T	Jed Jed	IE ECHAIC					
for use as t	Physician/Med	200 Mas decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	uth 3 DEctoric access		23d. Date of deliv	rery
detached for	sicie	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death	ath 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
tach	hys	9 Unknown	9□ Unknown				
d be det	by P	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
should b					1 🗆 Yes	2□No 3□Pro	bably 4. Unknow
sho	Completed				24a. Was an	24h Wara aut	opsy findings available
age	E				autopsy	prior to co	opsy findings available ompletion of cause of
or. p	ပိ	25. Was case referred to medical			performed 1 ☐ Yes 2 D	No 1 ☐ Yes	2 No
90 9	∞	examiner?	Hospital:	Other	ath Check only on		
9	၉	1 ☐ Yes 2 ☐ No	1 Minpatient 2 ER/	Solpatient SD DOX 4 Nursing	Home 5 Residence		fy)
funer i	<u></u>	1 ⊠Natural 5 ☐ Pending	(Month, Day Year)	Injury Work?	28d. Describe how i	njury occurred	
ţ.	Sa	2 Accident investigation 3 Suicide 6 Could not be	20 a Place of Injury At home		00/1		
d in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	rarm, street, factory, office	City or Town, S	t and Number or Run tate)	al Route Number,
	edicai C	29a. Certifier 1 Certifying Phy (Check only one) 1 Certifying Phy 2 Medical Exami	sicien: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
completely		29b. Signature and title of certifier	and mailler stated.	29c. License number		Date signed (Month,	
				Individual	230.	Jaco signed (MONIA),	way, rear/
0		1 1/1		om	1 -1	1.	
Ÿ	1	- Control	MD.	D 00 59 736	Te	man 28	2006
Ÿ		30. Name and address of person who co	ompleted cause of death (Item 23a		Te	Druan 28	2006

			2, State of Maryland / De Registrar Amend Item 26 per Dr., G853,0	epar 3/0	tment of I	Health Death	and M	ental Hyg	jiene	06	061.1	12
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		/2006	3. Time of Dea	
	/Medio Examin	al	Marian A. Gottke 4a. Facility Name (If not institution, give street and number)	4	4b. City, Town, o	or Location	n of Death	-02		y of Death	1402	М
			Suburban Hospital		Bethe				Мо	ntgom	ery	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	N	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day, 06-29-	, Year)	9. Birthpl Count Oh:		oreign
	land DW		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	or Loca	tion				1720		Od. Inside City L	imits
	the Marylan 28a-f show notitied at	ctor	MD Montgomery Chevy	Cha	se						1y⊟yYes 2[	
	within 72 hours after death with the Maryland jiene. rthan "natural", or ttema 23a or 28a-f show the Medical Examinat must be notified at	by Funeral Director	10e. Street and Number 4114 Blackthorn St.		10f. Zip Code	2081	.5	1	0g. Citizen of USA	What Coun	try?	
	ter death Itema 2 ner mus	unera	Armed Forces?	13. Wa If Y	s Decedent of H	Hispanic O	rigin? (Specan, Puerto F	cify Yes or No- Rican, etc.)		ce - America		
036	ours afte sl', or i		1 Never Married 2 Marned 1 Yes 2 No If Yes, Give Year or Dates:	1 🗆	Yes 2√No	Specify	y:			v: Whit		
Maryland 21215-0036	in 72 hours "naturs!" bedical Ex	Completed	(Specify only highest grade completed) (G	eceden	nt's Usual Occup ad of work done NOT use retire	oation during mo	st of workin	g	16b. Kind of E	Business/Ind	ustry	
212	TO 12 IN 188	Comp	College (1-4or 5+)		maker	····			Ow	n Home	9	
and	d be filed intal Hygi ed other	Be	17. Father's Name (First, Middle, Last)					(First, Middle, M		•		
aryl	2 should be it and Mental is marked or	은	Frederick August Kardatzke  19a. Informant's Name/Relationship (Type, Print)  19b. M	failing /	Address (Street			eckler Route Number,			Code)	
	s 1 and 2 should be filed if Heelth and Mental Hyg Item 27 is marked othe other traumatic event,		Robert C. Gottke/son 12	14 1	Raymond		McLea	n VA 22	101			
L SU altimore,	ages I ant of H nt: If Ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Other (Specify)  20b. Place of Disposition State  Uniform	cremat	ory`or other plac	f . 1			20c. Location			
Paltin	permit. Pages Depertment of Important: If It any injury or o	1	21. Signature of Funeral Service Licensee	1th 22. N	Science lame and Addre	ess of Facil	lity	21-2006		thesda	a MD	
*	g		23a. Part1. Enter the disease, or complications that caused the death. Do not	Ray	pp Funer 3 Gist /	ral & <del>Av Si</del>	Crem	ation S <del>Spring</del>	ervice MD 209	s 10	A	
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		0 0	lg, such as	·	respiratory arre	151,		Approximate Interval Betweer Onset and Deat	n h
	/Medical Examiner		Due to (or as a consequence of):		C	~	\	D				
2	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2 1	Colour	2 14	,	D Scens	,			
in the	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):	Ĥ	pert	rai	lure					
1000 8760	8 9 9	dical										
Se	ath certificate attending physic for use as the last the	/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy						22d Da	ite of deliver		
30.	000	hysician/Me	in the past 12 months?		topic pregnancy ther (specify)	′			1		y Day Year	
Zds,	The law requires that the site has been signed by the axe 2 should the detached	g D	Part II. Other significant conditions contributing to death but not resulting in the Chronic Obstructive Rimono		orlying cause giv	en in Part i	1.				cause of death	
Aecord	hesber hesber	ompiete	Peripheral Vascular S	Dis	sease			24a. Was an autopsy perform	24b.	Were autop	sy findings avail pletion of cause	able of
tal		O .	25. Was case referred to medical	_		26 Place	e of Death		No	1 Yes 2	?□ No	
350	hysici this ce at dire	TO B	examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpat		3□ DOA Oth	er: 4 🗆 No		e 5 Resider	7.	er (Specify)	Fax: Cas	,
elens	ttending Physicien: death. stor: After this certifica r the foreral dire to.	cution:	27. Manner of Death  1 ✓ Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	ry	28c. Injun Wori M 1 []	yal k? Yes 2. ☐		3d. Describe how	w injury occur	red		
Divi	A pire	Certif	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street,	factory, office		28	3f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely (Hed	Medicai	29a. Certifier (Check only one)  1 ★ Certifying Physicien: To the best of my knowledge, de  2 ★ Medical Examiner: On the basis of examination and/or and manner stated.	eath oc r invest	curred at the time tigation, in my of	ne, date ar pinion, dea	nd place, an ath occurred	d due to the car d at the time, da	use(s) and ma te and place,	anner as sta and due to t	ted. he cause(s)	
	within 2 To the	Σ	29b. Signature and little of certifier		29c. License		2011	_	d. Date signe			
16	1/2	-	30, Name and address of person who completed cause of death (Item 23a) (Type	oe, Prin	1000	744	574	te	Loruck	y 17, 7	2006 dq MD2	
	)		Philip Strauss, MD Suburban H 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ital 86	00 0	10 Ge	orgetau	n Roce	l between	da, MD2	484
	Stat Registra	-	MAR 0 3 2006	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month John Joseph Gleason 2203 FEBRUARY 27 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Ctr. Baltimore City N/A6. Sex XXM 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 79 Director 219-10-0698 Maryland June 15,1926 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at Colgate 1 ☐ Yes 2 No Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 7745 Wynbrook Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married Maryland 21215-0036 1 ☐ Yes 2€XNo δ WWII Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheraton Hotels 12 Years Hotel Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 Is marked ott John W. Gleason Anna M. Hill 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathleen Cortolillo 7743 Wynbrook Road Baltimore, Maryland 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If Ite any injury or ot once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 3/3/2006 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 238 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bsuper Disease **Physician** Atheroscherotiz Coroham rears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed ng physicien and as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death signed by the a 5 Other (specify) 2 🗆 No o 9. Unknown 9 □ Unknown يَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 X Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has autopsy performed? Yes 25 No certificate 1□ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 15€Yes 2 No To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 28684 Deamar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayerew reducal lenter Gess man MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 0 3

2008

	70		For State Registrar	State of N	Marylan	-	artmen rtificate			and M		Reg. No.	06.	0 6 L <sub>3</sub>	Death
	Physici	an	1. Decedent's Name (First, Middle, L								Month MARCH	Day	200 G	3:05	
	/Medic		Geraldine Ann H		ər)		4b. City,	Town, or	Location of	of Death	MAKUT		unty of Death		
	Examin	lei	ST. AGNES	Hospit	AL		Be		mo			Ba]	ltimore	9	
-	Funeral Director	Œ.	5. Social Security Number 6. 219-40-9848	Sex 7. 1 □ M 2 1 F	Age (in yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da: 07/19	v. Year)	Cou	place (State o ntry) ryland	r Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	ity Limits
	Maryl	to	MD Balti	more	Ba	altimon	ce							1√ Yes	2 🗌 No
	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
	th wit	alD	1706 Wickes Aver	nue				2	21230			Unite	ed Stat	tes	
36	be filed within 72 hours after death with the Maryland tall Hygiene. Ad other then "natural", or items 23s or 28s-f show event, tre Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tes S If Yes, Give Year or Date	s? □ No		Was Deced If Yes, spec				ecify Yes or No Rican, etc.)		Race - Ameri Black, White ecify: Wh:	etc.	
ŏ	2 hou		15. Decedent's (Specify only highest of			16a. Dece	dent's Usua	I Occupa	ation	t of work	na	16b. Kind	of Business/Ir	ndustry	
21215-0036	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of woi				,,,9	Dood	Commi		
	filed with Hygiene. other ther	S		- 41		rood	Serv	rce/1			(First, Middle,		Servi	ce	
	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Las										mame)		
2	s 1 and 2 should be f Health and Menta item 27 le marked other traumatic ev	은	Earl Roy Reichar  19a. Informant's Name/Relationship			19b. Mailir	na Address	(Street a			onica S		own, State, Zi	p Code)	
<b>≅</b>	od 2 sho lith and 27 te ma		George E. Hamilt				•	,			timore,			,	
ē,	s 1 an of Heal item	- 89	20a. Method of Disposition			lace of Dispo	sition (Nan	ne of			Date		ion - City or T	own, State	
Ë			1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec							03/0	6/2006	Balti	imore,	MD.	
Baltimore,	permit. Pag Department Important: t any injury o		21. Algrature of Funeral Service Lic	ense de la	<u>,</u>		2. Name an 1107 <i>V</i>			110	bbard F e, Balt				
	Physician /Medical Examiner /Medical physician /Medical physician /Medical physician /Medical physician /Medical physician /Medical physician /Medical /Medi	i Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or C.	as a consequence as a c	uence of):	Pho	eum	ARCI	a_				Interval Bet Onset and I	
P.O. Box 68760	the death certificate by the attending phy ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  Part II. Other significant conditions	d	n 2 ☐ Feta tat time of d	l déath 3[ leath 5[	Ectopic pr Other (sp	ecity)	en in Part		23e. Did t		Date of deline Month contribute to		Year
ds,	uires tha signed Id be del	d by		J		, and the second	, ,				101	Yes 2 N	lo 3 🗆 Pro	bably 4 🗆t	Unknown
Records,	The law requir cate hes been s page 2 should	Completed									24a. Was autop perio			opsy findings ompletion of c	
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of V	9 W 17	10	1 ☐ Yes 2 💢 No	Hospital: 1 XInp	atient 2	ER/Outpatie	nt 3 DC	OA Oth	er: 4 🗆 Ni	ursing Ho	me 5 Resi	dence 6	Other (Spec	ify)	
0	ding Phy h. After thi funeral o		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of t (Month,	njury Day Year)	28b. Time o Injury		Bc. Injun			28d. Describe	now injury o	ccurred		
Division	I or Attendii after death. Director: A I in by the fu	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At h , etc. (Specil	ome, farm, st	M reet, factory		Yes 2 🗆	No	28f. Location ( City or To		lumber or Ru	ral Route Num	nber,
u	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edicai Ce		Physician: To the be aminer: On the basi and manner	s of examina										s)
	o the	Med	29b. Signature and title of certifier	L.		<	290		e number			29d. Date s	igned (Month	Day, Year)	
	- 3 - 5		Atta	Ng			m	OPE	0025	50	C	3/0	1/200	06	
	l l		30. Name and address of person wh	o completed cause	of death (Iter	т 23a) (Туре,	Enu	e .B1	AUTIM	loké	MO.	2122	29		
	Sta Regist	ate	31. Date filed (Month, Day, Year) MAR 0 3 20	~GNA 90	istrar's Sign	ature And	of the								

HAMILTON, GEFALDINE

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Q.			1 - For State Registrar	'State of M	aryland /	Cert	tment of ificate of	Health and		eg. No.	16	06415
	9		Decedent's Name (First, Middle,	Last)			7,0410 07		2. Date of Deat	th		3. Time of Death
	Physici /Medic		Stephan	Van	Hanks,	Jr.			Februar	Day v 23 2	Year 2006	5.40 P M
	Examin		4a. Facility Name (If not institution,			1		or Location of Deat	h	4c. County	of Death	
			548 Old Waugh C		je (In yrs. last t		Odenton  If Under 1 Year		8. Date of Birth	Anne		
	Funeral Director		217-84-2381	1⊠M 2□F	39		Months Day			Year)	Mar	place (State or Foreign intry) y Land
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loca	tion					10d. Inside City Limits
	Maryli	for	MD Anne Ar	rundel	Odent							1 □ Yes 2 No
	th the or 28a and i	irec	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Col	intry?
	ath will	ral	548 Old Waugh (				2111			USA		
	item item	Funeral Director	11. Marital Status 1 → Never Married 2 → Marrie	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 🔯	•	13. Wa	as Decedent of res, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ce - Amer ck, White	ican Indian, , etc.
036	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		10	JYes 2Ã N	o Specify:		Specify	": Wh	ite
5-0	72 hg	eted	15. Decedent's (Specify only highest	Education grade completed)	16	(Give kii	nt's Usual Occi	e during most of wa	rking	16b. Kind of B	usiness/l	ndustry
21215-0036	2 should be filed within 72 hours after death with the Maryland i and Mental Hygiene. ie marked other than "netural", or iteme 23a or 28a-f ehow raumatic event, the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	_	NOTuse retir	·ed)		Constr	ucti	on
<b>P</b>	e filed I Hyg other	Be C	17. Father's Name (First, Middle, La	ast)				18. Mother's Na	me (First, Middle, I			
ylaı	Menta Menta arked	To	Stephen Van Hai					Barb	ara Dale	Sherme	r	
Maryland	s 1 end 2 should f Health and Mer frem 27 ie marke other traumatic		19a. Informant's Name/Relationshi			_		etand Number or Ri Loop Road				p Code)
<u>စ</u> ်	Healt Healt tem 2 other		Stephen Hanks, 20a. Method of Disposition	Sr. (Fath	-		ion (Name of tory or other pi			VA 24. 20c. Location -		own, State
e E	Pages nent of int: if i		1 <sup>A</sup> Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe						3/1/06	Gretna	, VA	
Baltimore,	permit. Pages 1 end 2: Department of Health ar Important: if Item 27 ie eny injury or other trau		21. Signature of Funeral Service Li	censee	~ 0	22.10 Co	Name and Add	ress of Facility Moran Fun	eral Home	2		
	<u>₹0</u> 5 ≅ a		ale sales	- W 0000	10V	JP.	0. box	400 Gre	tna, VA	24557		Annewimete
			23a. Part1. Enter the disease, or c shock or hear failure. List or Immediate Cause (Final	nly one cause on each li	ne.	a not enter	the mode of dy	ring, such as cardia	c or respiratory arm	est,		Approximate Interval Between Onset and Death
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ć	execut n and ial-trar	Exan	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	e of):					-	
1760	ite be iysicie			d								
89	ertifica ling ph e as th	Med	IF FEMALE:							-1	1	
P.O. Box 68760,	attend for us	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea		ctopic pregnan	су			te of delik	rery Day Year
o.	the de	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	tano or doath	300	ottier (specify)					
č.	ss that gned b	by P	Part II. Other significant condition	s contributing to death b	out not resulting	in the und	erlying cause g	jiven in Part I.	23e. Did tob	acco use cont	ribute to	the cause of death?
Records,	requir een si nould								1 🗆 Ye	s 2 No	3 🗆 Pro	bably 4 Unknown
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Ž	ysicie is cert direct	To B	examiner? 12 Yes 2 No	Hospital:	ent 2 ER/0	Dutpatient	3□ DOA O	ath	ath <i>Ch∂ck only on</i> forme 5 ☐ Reside		er (Spec	scene
0	ng Ph Ater th Ineral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury	28c. lnj	ury at ork?	28d. Describe ho	w injury occur	red	01
Division of Vital	death.	icati	2 Accident investiga 3 Cuicide 6 Could no	t be	23 (06	17257	coupy	Yes 2 No	281 Location (St	root and Numb	37 F	al Route Number,
Div	efter Direct d in by	Certification:	4 Homicide determin	building, et	c. (Specify)	1 1	Ace	9	City or Town	State) 5	4809	dweigh,
	lospita hours uners ity fille	cai	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	Physician: To the best caminer: On the basis of	of my knowled	ge, death o	occurred at the	time, date and place	a, and due to the ca	ause(s) and ma	anner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medi	one)  29b. Signature and title of certifier	and manner st	ated.			nse number		9d. Date signe		
	5 ± ₹ 5			MY	-0/	_	OCME			Februar		•
	5		30. Name and address of person w	no completed cause of c	death (It) m 23a	i) (Type, Pr	int)				_	
	*		THEUDONE	M. King		1	L11 PEn	n Street,	Baltimon	ce, Mar	ylan	d 21201
9	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 3 20	05 Page	ar's Signature	Cours	6					
		-	0 20	The state of the s	- Salar	Car San	1 Accept					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Physician 7: 40AM Thelma 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlestown Retirement Community Baltimore Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March | 19,1912 | Massachusetts Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 1 F 93 218-30-5919 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 7 is marked other then "neturel", or items 23a or 28a-f show traumatic event, it a Modical Evertiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 342 Cottswold Place U.S.A. 21140 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Maryland Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event, IL & MORGE. Claims Representative Underwriters Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Parker Robert Grau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 Cottswold Place, Riva, MD Waldimar F. Horak, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State \*4 □ Donation 5 □ Other (Specify) Moreland Mem'l Park 3/3/2006 Baltimore, Maryland 21. Signature of Fineral Sprice Licensee 22. Name and Address of Facility Schimunek Funeral Homes the the 9705 Belair Road, Bactimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metabolic acidosis **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner burial-tran and Due to (or as a consequence of) the attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ģ in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown been signed by I should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Pulmonar 1 Yes 2 No 3 robably Obstructive 4 🖸 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No After this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/28/06 144377 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) choice Lane, Catansville, mo 21228 711 Maride mo Deneen Boulin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 3 2006 Registrar

			For Stete Registrer	Sta	ate of	Maryl	and / [	•		nt of H <i>te of L</i>			fental Hy	giene Reg. No	2110	6	0641	7
ı	Physici		Decedent's Name (First, Middle		orot	hy Ma	e Hil	ker			-		2. Date of De Month Februa	Da		ear 106	3. Time of Death 10:30 P	
	/Medic Examin		4a. Facility Name (If not institution	, give street	and num	iber)			4b. City	, Town, or	Location	of Death			. County of [			
			Ivy Hall Nurs	ing Ct	r.					Midd					Balt	imo	re	
	Funeral Director		5. Social Security Number 218–26–2008	6. Sex 1 ☐ M 2		7. Age (In ) 76	yrs. last bir	thday) Yrs.	If Unde Months	Days	If Unde Hours		8. Date of Bi (Month, Da July	rth a <i>y, Year)</i> 21 <b>,</b> 1	929	Count	ace (State or Fore ry) Yland	ign
	put *		Usual Residence of Decedent  10a. State 10b. County			10c	. City, Tow	n or Lo	ration							10	d. Inside City Lim	uits
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	the 128a-	Director	10e. Street and Number						10f. Z	ip Code				10g. Ci	tizen of Wha	t Coun	try?	_
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	me 2	Funeral	11. Marital Status		as Dece	dent Ever i	in U.S.	13. V	Vas Deci	edent of H	ispanic C	rigin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race - A			
9	filed within 72 hours after death with the Marylan Hygiene. ther than "natural", or Iteme 23s or 28s-f show int, the Medical Examinar neat by notified at	by Fu	Never Married 2 Marr	ed 1 (	∃Yes Yes, Give	2 🛣 No				2[X]No	Specif		, , , , , , , , , , , , , , , , , , , ,		Specify:			
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<u>8</u>	d 2 st th and treur		Mrs. Lois Paul				190		•	Edg <b>e</b> m							21219	
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ż	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a]	End	Stage	Park	ins	on's	Dis	ease					u	nkn.	
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8/60,	oe exe		resulting in death) Last		Due to (d	or as a con	sequence	of):										
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			<b>&gt;</b> //\\							387	54			02	21	0 -	2006	
	3		30. Name and address of person Malika Waseem							Balti	more	, Mar	yland	212	21			
	Sta	te	31. Date filed (Month, Day, Year)															
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician John Jenifer 21, 2006 February 8:52 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2530 N. Calvert Street #100 Rear N/ABaltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 100M 2□F Hours 219 384434 6.3 MD. Director Usual Residence of Decedent tiled within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinan in the notified at Md N/a Baltimore 1 X Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number # 100 21202 2530 N. Calvert Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Black ģ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Custodian permit. Pages 1 and 2 should be tiled will Department of Health and Mental Hygient Important: If tiem 27 is marked other that any injury or other traumests. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen James Jenifer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 N. Amity Street #6 Baltimore Md. 21223 Darlene Mason 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Carmel Cemetery 3/03/06 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk Maryland \* 4 □Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 23a. Part Forer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5240 Reisterstown Rd Baltimore MD. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer LUM9 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 Yes this certificate 2 X No 1 Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: , completely tilled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number Karani - 000 ,28,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Hospita ALI LANKARANI, Simou 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SOL Registrar MAR 0 3 2006

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	Physicia		Bernard	J	amis	son				Feb	ruary	<sup>Day</sup> 3, 2006	4:35 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and nu		00.1	4b. City	, Town, or	r Location of Dea	ith		4c. County of Deat	h
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83	Funeral Director			<b>Q</b> M 2□F	48	Yrs.	Months	Days	Hours Min	000	nth, gay, Y	1957 Ne	W YORK
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or L	ocation			-			10d. Inside City Limits
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ary	and Mand Me mark	۲	19a. Informant's Name/Relationship (T)	ype, Print)	daughte	19b. Mai	ling Addres	s (Street	and Number or F	Rural Route	Number, (	City or Town, State, 2	Zip Code)
	and fealth m 27		MS. Bernadett 20a. Method of Disposition	ie Ja	misor	Place of Disp	Consition (Na	2.FF	rage (	Date	Se	Oc. Location - City or	10 21144 Town State
or I	ages I int of the t: If ite		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		State /	comotory, critical Mo	ematory or	other plac	1 12/2	3/20	DAF	Salto 1	Nd
Baltimore,	permit. Pages 1 Department of F Important: If ite eny Injury or ot	l V	21. Signatore of Funeral Service Licens		2	ieen in	22. Name a	and Addre	sa Facility		acal	House 1	) A
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ds,	signed d be d	þ	Part II. Other significant conditions co	ontobuting to t	death but not re	sulting in the	underlying	cause giv	ven in Part I.	2.5		2 □ No 3 □ Pr	A
cor	s been s shoul	Completed								24	a. Was an	24b. Were au	utopsy findings available completion of cause of
- Be	sician: The law scertificate has b lirector, page 2 s	Com								15	autopsy performe Yes 2	ed? death?	2 No
Vita	ician: certific ector,	Be	25. Was case reterred to medical examiner?	Hospital:	7	7		Oth	26. Place of D				
of	Phys or this oral dir	. To	14 Yes 2 No 27. Manner of Death	1 (_	Inpatient 2£ e of Injury nth, Day Year)	ER/Outpati	ol	28c. Injur Wor	4   Nursing			ce 6 □Other (Spe injury occurred	cify)
lon	ath. rs: Afte	ation	1 Matural 5 Pending 2 Accident investigation		ntn, Day Year)	Injury	М		rk? ]Yes 2 ☐No				
Division of Vital Records,	or Atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Plac	ce of Injury - At I ding, etc. <i>(Spec</i>	home, farm, s rify)	street, lacto	ory, office		281. Lo Cit	cation (Stre ty or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria		(Check only 2 X Medical Exam	ysician: To th	ne best of my kr	nowledge, de	ath occurre	d at the tir	me, date and pla	ce, and du	e to the cau	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
8	o the Pithin 24 o the Pithin 24 or the Pithin 24	Medical	one)  29b. Signature and title of certifier		nner stated.	7.			se number			d. Date signed (Mont	
	F 3 F 8		) That	11-	Va -	44.0		0.	.C.M.E.		F	ebruary 2:	3, 2006
	NY		30. Name and address of person who o		use of death (Ite								
	<i>U</i>		THE DOOMS MIGHT 31. Date liled (Month, Day, Year)	2	Registrar's Sign	11.	l Peni	n Str	reet, Ba	<u>ltimo</u>	re, M	aryland 21	L201
5	Regist	ate rar	MAR 0 3 2008	6	Registrar's Sign	The first	ack)						

3:40 a.m.

		For State Registrar	State of I	Marylan			nt of H te of L		and M	ental Hy	giene Reg. No	1 U L		06420
Dhuciaic	20	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	Da	ay	Year	3. Time of Death
Physicia /Medic		Philip	N.		Jac	chel:				March .	_	2006		3:40 A <sup>M</sup>
Examin	er	4a. Facility Name (If not institution,		er)			, Town, or	Location of	of Death			County		
		Stella Maris - 7 5. Social Security Number		Ane (in vrs	last birthday)		vSON er 1 Year	If Under	24 Hrs.	8. Date of Bir	1		more 9. Birtho	lace (State or Foreign
Funeral Director		218-03-0781	1 <b>½</b> M 2□ F		94 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da October	2. 1	911	Mary.	try)
		Usual Residence of Decedent												
how		10a. State 10b. County			y, Town or Lo	cation							11	Od. Inside City Limits
Ba-f-	cto	Maryland Baltin	iore	Du	ndalk 									1 ☐ Yes 2X No
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In an inarked other then "natural", or iteme 23s or 28s-f show amatic event, the Modical Examinar must be notified at	al Director	10e. Street and Number 2499 Fairway					ip Code 21222				10g. Ci US		Vhat Coun	try?
deat	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Dec	edent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	)-		e - Americ	
or its		1 Never Married 2 Marrie	ed 1 ☐ Yes 27 If Yes, Give	ŽΝο		1 🗆 Yes	_	Specify:	,	, ,		Specify	_	nite
ural',	d by	3 Widowed 4 □ Divorced	Year or Date	s:			••	tian.			105 6	Cind of D	usiness/Inc	
n 72 nat	Completed	15. Decedent' (Specify only highest	grade completed)		16a. Deced (Give	kind of w	rork done d use retired,	luring mos )	t of workii	ng	100.1	KING OF BU	1211162271116	dustry
withi iene.	EO	Elementary/Secondary (0-12) 12 years	College (1-4c)	or 5+)		rint					Edu	ıcati	onal	Department
e filed I Hyg othe	0	17. Father's Name (First, Middle, L	ast)		, <u> </u>					(First, Middle		n Suman	1e)	
uld be Menta rked tic ev	To B	Joseph Jachelsk	L					Hele	en Zi	elinsk	1			
2 short and his ma		19a. Informant's Name/Relationsh				•	•			l Route Numb		or Town,	State, Zip	Code)
and and m 27 m 27 rer tr		Charlene Triple	t Daught		4		T. Taractus			Md. 21				
Pages 1 nent of He int: If Iter		20a. Method of Disposition  1 Surial 2 Cremation	3 □Removal from Sta		Place of Dispo				Marc	ch 4,			City or To	
Pag tment tent:		4 Donation 5 Dother (Sp		St.	Stani									aryland
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natureny in Jury or other treumatic event, the Medical Once.		21. Signature of Funeral Service L	1 ( 0	nsil	Vey 7	110	Solle	rs Po	oint	me Of Road,	Dunc	dalk, dalk,	P.A. Md.	21222
		23a. Part1. Enter the disease, or shock, or heart failure. List	omplications that cau nly one cause on eac	sed the deat h line.	h. Do not ent	er the mo	de of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_ a _ PROST	ATE CA	NCER								8	Grisor and Boarn
/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):									
	<u>ا</u>	Sequentially list conditions,	b. Due to for	as a consed	uence of									
ted nsit	- In	cause. Enter Underlying Cause (Disease or injury	-		* TTT 12									
execu n and ial-tra	Examiner	that initiated events 'resulting in death) Last	Due to (or	as a conseq	quence of):				_					
cete be executed physicien and the burial-transit	dlcal		d.											
ng ph	Med	IF FEMALE:	1								- 1			
ires that the death certifications the attending signed by the attending die detached for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco			Ectopic	pregnancy						te of delive	Pry Day Year
e dea the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□ Unknow		leath 5	Other (	specify)							<b>Duy</b>
hat th od by detac		Part II. Other significant condition	s contributing to deat	h but not res	sulting in the u	nderlying	cause give	n in Part I		23e. Did	tobacco	use cont	ribute to th	ne cause of death?
Attending Physician: The law requires that the death certific death redistributes that the stranger of the funeral director, page 2 should be detached for use as	d by		3			, .				1 🗆	Yes 2	2 🗆 No	3 Prob	ably 4 🛣 Unknown
v requir been s should	ete	***************************************								24a. Was	an	24b.	Were auto	psy findings available
he lav e has	Completed									auto perfe	psy ormed?		prior to cor death?	npletion of cause of
ding Physician: The Ing. After this certificate he funeral director, page	ပို	25. Was case referred to medical						26 Place	of Death	1 Yes		0	1 🗆 Yes	2□ No
ysicle s cert direct	OB	examiner? 1 ☐ Yes 2 🗽 No	Hospital:	atient 2	ER/Outpatier	nt 3 🗆 🛭	Othe	200				6 X Oth	er (Specif	HOSPICE
g Phy erthi	L ii	27. Manner of Death	28a. Date of	njury Day Year)	28b. Time o	f	28c. Injun Work			28d. Describe				
tendin Jeath. tor: Aft the fur	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	ation		,	М		Yes 2□	No					
or Attending Ph after death. Director: After th	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 200. Flace of	Injury - At h etc. (Special	ome, farm, str fy)	eet, facto	ory, office		:	28f. Location ( City or To			er or Rura	l Route Number,
ris af														
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	29a. Certifier 1X Certifying (Check only 2 Medical E	Physician: To the be xaminer: On the basi and manner	est of my kno is of examina r stated.	ation and/or in	vestigation	at the time on, in my op	ne, date an pinion, dea	ith occurr	and due to the ed at the time,	cause(: date ar	s) and ma nd place,	anner as si and due to	tated. the cause(s)
To the To the To the complex c	Me	29b. Signature and title of certifier	)			2	9c. License	number			29d. D	ate signe	d (Month,	Day, Year)
X			1				DI	1372	LS			3/	2/0	6
10		30. Name and address of person v	who completed cause	of death (Iter	т 23а) (Туре,	Print)								
t		DR. TARIQ MAHM			EY VALI	EY I	D.	LIMON	IUM,	MD 210	93			
Sta Registr		31. Date filed (Month, Day, Year)	7006 320 Reg	istrar's Signa	ature	salla.	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:00 PM 2006 02 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner G000 SAMARITAN BALTIMURE HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F Months Days Hours Min 6932 242-80-6932 Usual Residence of Decedent Yrs. Director North 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at Baltimore 1 Yes 2 □ No Director MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 1116 venue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Todes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ◯ No Specify ac 3 Widowed 4 Divorced "natural", other traumatic event, the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) eur 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ant: If item 27 is marked o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BaltoML 20b. Place of Disposition (Name of cametery, crematory or other place) Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o **Z** Burial 2 ☐ Cremation 3 Removal from State ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee laur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyind shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician HAEMORRHAGE INTRACRANIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 No 2E] No 1 🗌 Yes 1 TYes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the nueros after death.

within 24 hours after death.

To the Funeral Director: After th funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No М 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MD RES 000 02.15.2006

State Registrar 31. Date filed (Month, Day, Year)
MAR 0 3 2006

KUMAR

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUTEET

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6000

SAMARITAN

HOSPITAL

BALTIMORE

			1 - For State Registrar	State of	Marylar		artmen rtificat					Reg. Ne.	16	0647	23
	Dhusiai		1. Decedent's Name (First, Mic	idle, Last)							2. Date of De Month	ath ARY 28.	Year	3. Time of E	
	Physici /Medic		Pokin	Kim							FERKU			10:4	} □ F-W
>	Examin		4a. Facility Name (If not institut Saint Jos	ion, give street and num eph Medic	al Ce	nter				Tows				timore	
	Funeral Director		5. Social Security Number 460-71-1210	6. Sex 7 1 ☐ M 2XX F	. Age (In yrs. 64	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da Sept. 8	th ly, Year) 3, 1941	9. Birthp Cour Sol	olece (State or otry) uth Kor	Foreign
	ס		Usual Residence of Decedent		14- 60									lod leside Cit	. 1 !
	arylar	_	10a. State 10b. Cour	nty		ty, Town or Lo							,	1 ☐ Yes	
	Ba-f	cto		imore	Ti	monium						10g. Citizen of	M/h = 1 C = 11		
	with ti	Funeral Directo	10e. Street and Number				10f. Zip	093				USA	Wilat Cou	itiy:	
	eath	erai	10 Faraday Dri	12. Was Dece	lent Ever in U	I.S. 13.			ispanic Ori	iain? (Sp	ecify Yes or No		ce - Americ	can Indian,	
	ter d	Ē	1 Never Married 2 M	Armed Fore	es? 2 🕅 No	ł					ecify Yes or No Rican, etc.)		ack, White,		
20	urs af	þ	3X Widowed 4 □ Divord	If Yos Give			1 🗆 Yes	2 <b>X</b> ) No	Specify:			Speci	ity: F	\sian	
2-003e	be filed within 72 hours after death with the Maryland stal Hygiene. ad other then "naturel", or Items 23a or 28a-f ehow event, the Madical Examinar must be notified at	Completed	15. Deced	ent's Education hest grade completed)		16a. Dece	dent's Usua kind of wo	al Occupa	ation during mos	t of work	ina	16b. Kind of 8	Business/In	dustry	
V	ithin	npie	Elementary/Secondary (0-12		4or 5+)	life.	DO NOT u.	se retired	)				1.1		
V	led w lygier her th	ပိ	12	lo ( act)		Hom	emake	r	18 Mothe	ar's Nam	e (First, Middle		Home		
yland	S E D	Be	17. Father's Name (First, Midd Si-dong Kim	e, Last)					Poki		Park	, ivaluari carra	,,,,,		
	s 1 end 2 should be I Health and Mental Item 27 is marked other treumatic ev	ဥ	19a. Informant's Name/Relation	nshin (Type Print)		19b. Maili	na Address	(Street a			al Route Numb	er. City or Town	n, State, Zip	Code)	
2	nd 2 s alth an 27 ts i		Tae Hwi Kim (				•	•			onium, [	-		093	
ē,	of Health Item 27 other tr		20a. Method of Disposition			Place of Disponentery, cre	sition (Nar	ne of			Date	20c. Location		own, State	
ē	Pages nent of int: if its iry or o		1 ☐ Burial 2 💆 Crematic 4 ☐ Doffation 5 ☐ Other		tate	lltop (				N3/N	2/2006	Towso	nn Ma	arvland	1
Бащтог	글 된 큰 글 .		21. Signature of Juneral Servi	An .		2	2. Name ar	nd Addres	s of Facili	ty Ruc	ck Tows	on Fune:	ral H	ome, Ir	٦C,
ñ	Depa Impo any i		Must	Stephen	Coste						uson, Ma				
3760,	Physician and wascian and the principal and the	icai Examiner	23a. Part 1. Enter the disease, shock, or heart failure. L'Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	RACRAI or as a consec	NIAL quence of):								Interval Betwo	eath
.O. Box 68	the death certific y the attending p iched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown		th 2 Feta int at time of c	al death 3[	⊒Ectopic p ⊒ Other (sp					l l	ate of deliv	-	'ear
S, L	8 50	ρ	Part II. Other significant cond	litions contributing to de-	ath but not res	sulting in the u	ınderiying (	ause givi	en in Part I	1.	23e. Did 1	obacco use co Yes 2 No	ntribute to t 3 ☐ Prol		eath? Inknown
fecora	¥ S S	Completed				-					24a. Was	an 24b psy prmed?	. Were auto prior to co death?	opsy findings a	vailable luse of
ē	sician: The la certificate he irector, page 3	ပို	DE Was soon referred to made	inal				-	OC Place	a of Door		ormed? 2 No	1 🗆 Yes	2 No	
Vital	Physician: r this certific ral director,	8	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	Hoppital: > /	patient 2	ER/Outpatie	nt 3□ D	Oth	or		th <i>(Check only o</i> ome 5⊟ Resi		ther (Speci	fv)	
o uc	Afte Iune	tlon: To	27. Manner of Death 1 ANatural 5 ☐ Per	28a. Date o		28b. Time o Injury		28c. Injun				how injury occu			
UNISION	or Atten offer deat Director: in by the	Certification:	3 Suicide 6 Cou	ild not be 28e. Place	of Injury - At h g, etc. (Speci		reet, factor	y, office			28f. Location ( City or To	Street and Nun wn, State)	nber or Run	al Route Numb	oer,
	Hospite 4 hours Funerel	Medical Co	29a. Certifier 1 Certification (Check only one)	lying Physician: To the cal Examinar: On the ba and mann	sis of examin	owiedge, dea ation and/or in	th occurred evestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and n date and place	nanner as s , and due t	itated. o the cause(s)	)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of cert		J. J. J. J. J. J. J. J. J. J. J. J. J		29	c. Licens	e number			29d. Date sign	ed (Month,	Day, Year)	
)	F 3 F ŏ		► OChi	M				T\1200	0639T	74		3/	1/06		
	^		30. Name and address of pers	on who completed cause	of death (Ite	m 23a) (Type	, Print)	201 4014	without of a	* 1			1 8		
_	5		IMRON E SI	DDTOI M	D. 7	601 0	SLER	DRI	LVE.	TOL	ISON. M	ARYLAN	D 21	204	
	Sta		31. Date filed (Month, Day, Ye	ar) 32. Re	gistrar's Sign	ature	100		*****		,				
8	Registi	टा	11.11.11.11.11.11	- CO	William William	Alex Section	-								

2006

FEBRUARY

ANNE KARDIAN

		•	For State Registrar	State of M		nd / Depa		t of H	ealth a		ental Hy			0642	Ō
	Physicia: /Medica	n il -	DORIS H. KENNE     A. Facility Name (If not institution, gingle)	DY	1		4h Cih	Town or	Location o		2. Date of Dea Month PEBRUM	Day "H	Year 2000 nty of Death		
	Examine Funeral		ST. AGNES  5. Social Security Number 6.	tolpital	ge (In yrs.	last birthday) Yrs.		TIN 1 Year	If Under 2	3	8. Date of Birt (Month, Da	, N	J/A	place (State or F	-oreign
	Director model		217-07-6967  Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				4/16/1	918		YLAND  10d. Inside City	
	with the Ma 3a or 28a-f	Funeral Director	MD         BALTT           10e. Street and Number           323 LEYTON ROAD	MORE		REIS.	10f. Zip		 6			10g. Citizen		1 ☐ Yes 2 intry?	<b>X</b> _1N0
960	perintificate, Mary yieling 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be nutified at once.		11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	Ever in U No			lent of Hi offy Cuba		gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White cify: WHI	, etc.	
24040	Definition (e.) Mail yilating Z.I.Z.1.3-00.30 Sermit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Manial Hygiene.  mportant: if Item 27 is marked other than "natural", or any njury or other traumatic event, the Modical Examples.	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12TH GRADE	ducation ade completed) College (1-4or	5+)	1	lent's Usua kind of wo DO NOT us EMAKE	rk done d se retired,	ation Juring most )	of workir	ng	16b. Kind of	Business/Ir J HOME	,	
1	should be file and Mental Hy marked other amatic event.	10 Be	17. Father's Name (First, Middle, Lasi GEORGE BRODERIC 19a. Informant's Name/Relationship	K		19b. Mailir	ng Address	(Street a	AL.	ICE :	(First, Middle, STARKEY I Route Numbe			p Code)	
	ges 1 and 2. t of Health at if Item 27 ie		MARY BEHNING/DAU  20a. Method of Disposition  1 ₺ Burial 2 □ Cremation 3 [		,   0	322 ( Place of Dispo	CHALFO sition (Nam natory or o	ONTE	DR.	CAT	ONSVILL ate	E, MD 20c. Location	2122 on - City or T	own, State	
	permit. Pa Depurtmen Important: any njury		4 Donation 5 Other (Speci		NE		. Name an	d Addres			JOHNSO	BALTIM N FUNE WSON,	RAL H	MD OME, P. <i>A</i> 1286	۹.
	Physician /Medical		23a. Rant. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that of use one cause on each	d the deat ine. 4 ES	h. Do not ent	er the mod	e of dying	g, such as	cardiac of	respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	en ath
03203	ysicien and will read to burial-transit	ical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conseq		1 1	NP	ARC	TIO				WEEK	CS .
2	The law requires thet the death certifica The law seen signed by the attending phoage 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	]Ectopic pr ] Other (sp						Date of deliv	ery Day Yea	ar
DOKUS Passida B	requires that	ered by P	Part II. Other significant conditions	contributing to death I	out not res	ulting in the u	nderlying c	ause give	on in Part I.		1 🗆 Y	′es 2□No	3 ☐ Pro	he cause of deal	known
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	+ 3 + 8		30. Name and address of person who	WURTA completed cause of				P-1	7610	0	E	ZEBRUA	ey,	26, 20 MD 21	06
	State	9	MUZTA ZA KAZMI, 31. Date filed (Month, Day, Year)	MD SY.	KINE	s Hose	PITAL	900	S.CA	4761	AVE,	PALTI	MORE	MD 21	229.
	Registra		MAR 0 3	2006	AST .	Alle A	2344	Ø.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 8 per fh 9853 3-13-06 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 01 2006 5:55P M RUFUS LYNCH, JR. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 28s any hijury or other treumatic avent, It a Medical Examinar must. once. Baltimore, Maryland 21215-0036

1 - For State Registrar

**Physician** 

**Funeral** Director

/Medical

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760

					h	4c. County of Dea	
	JOSEPH RICHE	Y HOSPICE		BALTIMORE CI	TY	N/A	
	5. Social Security Number 6		(In yrs. last birthday)		8. Date of Birth	Year) 9. Bir	thplace (State or Fo
	242-42-4398	1 XM 2□ F	81 Yrs.	Worters Days Hours Will.	05/ <del>12/</del>	1924 N.	CAROLI
-	Usual Residence of Decedent						
	10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City L
ţ	MD N/A	1	BALTIM	ORE CITY			1 XYes 2
۵	10e. Street and Number 2538 FREDERIC	K AVENUE		10f. Zip Code 21223	10	g. Citizen of What C	ountry?
Funeral	44.44-9-10-1	12. Was Decedent Ev	ror in II S 12	Was Decedest of Hispania Osigin2 /5	Coopin Voc or No	14. Race - Am	onon Indian
Ë	11. Marital Status	Armed Forces?		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, Whi	
5	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▓ Divorced	d 1 ☐ Yes ŽQNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛱 No Specify:		Specify: I	BLACK
Completed	15. Decedent's (Specify only highest)		(Give	dent's Usual Occupation  kind of work done during most of wo	rking 1	6b. Kind of Business	/Industry
ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			
Ö	12TH		U.:	S. AGENT		C.I.A	
0	17. Father's Name (First, Middle, La	ist)		18. Mother's Na	me (First, Middle, M	aiden Sumame)	
To B	RUFUS LYNCH,	SR.		MATTI	E GREEN		
-	19a. Informant's Name/Relationship	o (Type, Print)	19b. Maili	ng Address (Street and Number or Ri	ural Route Number.	City or Town. State.	Zip Code)
1	DOROTHY WHITE			4 OAKWOOD, JES		•	
-		7 112505					
	20a. Method of Disposition  XBurial 2 ☐ Cremation 3	□ □ Bemoval from State	20b. Place of Dispo	matory or other place) EM. PARK 3/10		Oc. Location - City or	
	4 ☐ Donation 5 ☐ Other (Spe		KING M	EM. PARK 3/10	0/06	WINDSOR	MILL, N
	21. Signature of Furieral Service Lic	censee 🗸 🔾	22	2. Name and Address of Facility Ho	OWELL FI	NEDAT. HO	MF 2120
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	resulting in death)	a Due to (or as	consequence of):	7 7/500			1001
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	that initiated events resulting in death) Last	c					
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State

Registrar

MAR 0 3 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIHORE GILCHRIST HOSPICE NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1⊠M 2□F Yrs. 1-20-214 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? Ie marked other than "natural", or Itema 23a or 28e-f ehow traumatic event, tro Medical Examinar must be notified at Yes 2 No Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number NASTER USA 32 Funerai 12. Was Decedent/Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No þ 3.X Widowed 4 □ Divorced ACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 Ie marked other than ' Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 +HGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. MONASTERY AVE. EE (DAUGHTER) BALTIMORE, MD 21224 DHERRIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or fown, State 20a. Method of Disposition 1. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) JARRISON FOREST CHUINGS HILLS, 22. Name and Address of Facility JR. FUNERAL HOME 21. Signature of Fugeral Service Licensee ULTON AVE. 140212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Stage **Physician** /Medical Due to (or as a consequence of). Examiner stersion 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ate has been signed by the ettending physiclen and page 2 should be deteched for use es the burial-transit be t Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEASE Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 X No completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number ( us who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
MAR 0 3 32. Régistrar's Signature State 2006 Registrar

		ļ,	1 - For State Registrar	State of Maryland	-	artment c				giene Reg No. 0 6	(	0642	8
	30		1. Decedent's Name (First, Middle, La	st)					2. Date of De Month		′ear	3. Time of I	Death
	Physici /Medio		VERNON ROWE	MITCHELL					FEB.	28, 200		5:00	Р М
1	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Tov	wn, or Location	n of Death		4c. County of	Death		
		2	CHAPEL HILL I				NDALLS			BALT			
Fire	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la ↑ 7. Type (In yrs. la	st birthday) Yrs.	If Under 1 Y Months D	ays Hours	ler 24 Hrs. s Min.	8. Date of Bin Month, Da	5/1926		nlace (State or ntry) RYLAND	
	Director		216-20-0615 2 Usual Residence of Decedent						00/00	3/ 1920	MA	XILANL	
	iand ow		10a. State 10b. County	10c. City,	Town or Lo	ocation						0d. Inside City	y Limits
	Mary -f sh	ρ	MD BALT	MORE OW	INGS	MILLS	5					1 🗌 Yes	2 <b>X</b> No
	r 288	Director	10e. Street and Number			10f. Zip Co	ode			10g. Citizen of Wh	at Coul	ntry?	
	uth with the Marylan 23s or 28s-f show	a D	4418 WYNFIELD	DRIVE		21	1117			USA			
	itams in	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent	t of Hispanic	Origin? (Spe	ecify Yes or No Rican, etc.)	- 14. Race	Americ White,		
98	or it	F	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 🗆 Yes 2 🖸			,	Specify:		JACK	
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d 2	Hygi Hygi ther		17. Father's Name (First, Middle, Last,				18. Mo	ther's Name	(First, Middle,	Maiden Sumame,		3011211	
an		To Be	JOSEPH MITCH	ELL			.TT	IT.TA	BARNET	יתי			
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	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		MARGARET E. MI	TCHELL/WIFE	441	8 WYNF	TELD	DR.,	OWING	S MILLS		MD 21	117
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E	Pages nent of i ant: if its ary or o		Maurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State	-	RIDGE		03/	06/06	PIKESV	ILI	E, MD	)
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			23a. Part. Enter the dispase, or com shock, or heart failure. List only	plications that caused the death.	not ent	er the mode o	f dying, such	as cardiac o	or respiratory a	rrest,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	Atheroscie	conc	Caro	liosas	cula	r Dis	case		Onset and D	eath
4	/Medical		resulting in death)	Due to (or as a conseque									
No.	Examiner		Sequentially list conditions.	b									
	D 15	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						ĺ		
	and -trans	каш	that initiated events resulting in death) Last	c	ance of):						-		
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87	phys the	Physician/Medical	•	d									
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Вох	atter f for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Fetal of 4☐Pregnant at time of dea		Ectopic pregr Other (specif				Mont			ear
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ita	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Pla	ace of Death	(Check only				
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2	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work?		28d. Describe	how injury occurred	1		
sio	death.	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2						
Division	or Attanding Physician: utter death. Director: Atter this certifics in by the funeral director, p	Certification:	4 Homicide determined			reet, factory, of	ffice		28f. Location ( City or To	Street and Number wn, State)	or Run	il Route Numb	) <i>01</i> ,
	spital lours a heral [		29a. Certifier 1 Certifying Pt	nucleisms. To the best of my know		h	de a de la constante de la con					4-4-4	
	Ful Ful stelly	Medical	(Check only 2 Medical Examone)	nysician: To the best of my know niner: On the basis of examination and manner stated.	on and/or in	vestigation, in	my opinion.	and place, leath occurr	ed at the time,	date and place, an	d due t	tated. the cause(s)	
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier			29c. L	icense numbe	er e		29d. Date signed	Month,	Dey, Year)	
	0		> Maun &	Balret, M.	D.	D	0058	676		March	2.	2006	
6	Y												
1	)		karen L. Babi	H, M.D., 25 N	rain S	weel,	Sylte	200 h	Zeister.	stown 1	1 D	2113	(
100	Sta		30. Name and address of person who Karen L. Bays.  31. Date filed (Month, Day, Year)  MAR 0 3 20	32. Registrar's Signatu	ILE NO	and the			-				
	Registi	ar .	MAK U 3 ZU	UU AND TO AND	Contract of								

RICK L. McCULLOUGH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Unpend item# 1,23a-b, PII,27, penME, 0854,4/12/06 TT

State of Maryland / Department of Health and Mental Hygiene

Amend item#1, penME, 0854, 4/13/06 TT

Certificate of Death

Reg. No. 06-01526 RJ 1 - For State Registrar 06429 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 28, 2006 **Physician** 7:17а. м Rick Lynn McCullaugh Rick Lynn McCullough /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

4.6 Yrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day Year) 9. Birthplace (State Country) Mary Land 9. Birthplace (State or Foreign **Funeral** 6. Sex 1₫M 2□F 46 219-80-1967 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 is marked other than "natural, or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Glen Burnie Maryland Anne Arundel 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 104 Wilson Blvd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) se filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be lift
Department of Health and Mental Hy
Important: if Item 27 is marked oth
any liqury or other traumatic event
908.8. Be Mary Elizabeth Howard Herbert Jesse McCullough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Moreland/ Brother 104 Wilson Blvd., Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State March 3, 1 □ Buria 2 Cremation 3 □ Removal from State 2006 Metro Crematory, Inc. Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Suneral Service License Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac arrhythmia /Medical Due to (or as a consequence of): Moderate coronary atherosclerosis and Examiner cjoronary myocardial tunnelling Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of) ng physician a Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Oate of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ right cardial ventricular dilation and hypertrophy with thrombi 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 N Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Division of Vital To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t Certification:

1 XYes 2 No

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 XNatural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

LING

mo

29c. License number OCME

29d. Date signed (Month, Day, Year)
March 2, 2006

30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) III Fenn Street RallImore, Marylind 212+1 ma

State Registrar

31. Date filed (Month, Day, Year) 2005

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			•	<b>pe or Print in B</b> State of Maryland				-	•	
			1 - State Registrar	State of Maryland		tificate of			No. 0 0 6	06130
			Decedent's Name (First, Middle, Last)					2. Date of Death	100	3. Time of Death
	Physici /Medio		CONTANCE	moore				Month	Day Year	1000 N
>	Examir		4a. Facility Name (If not institution, give stre	et and number) 750	2	4b. City, Town, o	r Location of Death	**	4c County of Dea	ath M
			Bradford Daks 1		Maloni	d Ulta	ton, mo.	20772	Prince	19
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, )	'ear) C	rthplace (State or Foreign ountry)
	Director		175-20-4522 Usual Residence of Decedent	92				Feb. 15,	1914 A	abama
	how		10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
	aa-fs	cto	MD Prince Ge	orge Cli	nton					1 □ Yes 2K No
	vith th	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	country?
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	iter d	Funerai	11. Marital Status 12.  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No	5.   13. <b>v</b>	Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto R	lican, etc.)	Black, Wh	
036	al', or	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2⊠ No	Specify:		Specify: B	lack
2-0	72 hours after death with the Maryland Insturet; or items 23a or 28a-f show dies! Exactinet mast be neithed at	Completed	15. Decedent's Educat (Specify only highest grade of		(Give I	ent's Usual Occup	during most of working	g 16	b. Kind of Busines	s/Industry
2	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	O NOT use retire	d)			
, D	filed v Hygie other t		17. Father's Name (First, Middle, Last)	2	Home	maker	18. Mother's Name	(First Middle Ma	Own Ho	me
Maryland 21215-0036	d be l	To Be	Mack McSwain				Viola Bu		idon camano,	
ary.	2 should be and Mental Is marked raumatic ev	F	19a. Informant's Name/Relationship (Type	Print)	19b. Mailin	Address (Street	and Number or Rural		City or Town, State,	Zip Code)
ž	Health a Health a tem 27 Is		Cynthia Collins		5030	Leland D	rive, Oxon	Hill, I	MD 20745	
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Madical Exertine mail te notified at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren	20b. Pla	ace of Dispos	ition (Name of atory or other place	Da	ite 20	c. Location - City o	r Town, State
Ĕ	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		'4 □Donation 5 □Other (Specify)	IOVAL ITOITI STATE		Cemeter		7,2006	Johnstown	, PA
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	00 6 00	V		ss of Facility Edwa			1 Home
	707 # 0		23a. Part1. Enter the disease, or complica	Joans			eet, Johns			Approximate
	/Medical Examiner	Examiner	shock or heart failure. List only one Immediate Cause (Final disease or concilion resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or minury that initiated events	Due to (or as a consequence to (or as a consequence)	ence of):	Sure				Interval Between Onset and Death
. Box 687	he death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or as a consequent of the consequent of	ncy death 3 🗆	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
Ś	w requires that the de been signed by the a should be detached	by	Part II. Other significant conditions contri	outing to death but not resul	lting in the un	derlying cause giv	en in Part I.	23e. Did toba	V	o the cause of death?
	8 S S	Completed						24a. Was an autopsy performe 1 Yes 2	prior to death?	utopsy findings available completion of cause of
<u> </u>	Physiclan: r this certific ral director,	Be	25. Was case referred to medical examiner?	pital:		act no. Oth	26. Place of Death			
ō	Phys r this ral di	): To	1 195 2 110	1   Inpatient 2   E	ER/Outpatient 28b. Time of	3 DOA 28c. Injur	4 Nursing Hom	e 5 🗌 Residen. 3d. Describe how	ce 6 Other (Spe	ecify)
0	Attending in death. ector: After by the fune	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2∐No		. ,	
DIVIS	I or Attendi after death. Director: A d in by the fu	Certification;	3 Cuicide 6 Could not be	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office	28	3f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  In the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifler (Check only one)	an: To the best of my know On the basis of examinational manner stated.	viedge, death ion and/or inv	occurred at the tirestigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the I	Me	29b. Signature and title of certifier	1		29c. Licens			. Date signed (Mon	-
	$\prec$		> Well- 10	no		D3	5206	F	95rum	28, Zev6
1	5		30. Name and address of person who comp	eleted cause of death (Item	23a) (Type, F	Print) Unggan	Rood F	int Was	Hington	47
	Sta Registr	43	31. Date filed (Month, Day, Year) MAR 0 3 2001	32. Registrar's Signatu	ure	and o			,	

		For State	State o	f Maryla	nd / Depa	artmen			and M	_	73	006	00101
		Registrar  1. Decedent's Name (First, Middle	[201]		Cei	runcau	e or L	Jean		2. Date of De	Reg. No	000	3. Time of Death
Physici		Mary Elmore	Moreland	1						Month Februar	Day	2006	91/52 M
/Medic Examir		4a. Facility Name (If not institution				4b. City,	Town, or	Location of		rebruar		ounty of Deatl	h
LAGITIII	161	Westminster Nu				Wes	stmi	nster			Ca	rol	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	th	Q Rint	hplace (State or Foreign untry)
		224-20-3590	1□M 2 <b>X</b> F	85	Yrs.	I WOTHERS	Days	Tiodis		Sept 2	7, 192	0	VA
and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
/anyli	ŏ	MD Carol		MA	stminst	or							1∭Yes 2 □ No
the the 288	rect	10e. Street and Number	-	, we	3 CM TH3 C	10f. Zip	Code				10g. Citizer	n of What Co	ountry?
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deat	Funeral Director	11. Marital Status	12. Was Dece Armed Fo		U.S. 13.	Was Deced	dent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	)- 14.	Race - Ame	
or Ite	by Fu	1 Never Married 2 Marr	ed 1 □Yes If Yes, Giv	2 ∰ No ∕e		1 ☐ Yes		Specify:		, , , , , , , , ,		pecify:	
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n 72 n mat	Completed	(Specify only highes	t grade completed)		16a. Dece (Give life.	kind of woi DO NOT us	al Occupa rk done d se retired	ation du <i>ring</i> mosi ()	t of workii	ng		lehem	industry
within than than	E O	Elementary/Secondary (0-12)	College (1	1-4or 5+)		cvisor		,			Stee	_	
other	BeC	17. Father's Name (First, Middle,	Last)			,		18. Mothe	er's Name	(First, Middle,	, Maiden Su	ımame)	
Viand uld be fill Aental H irked oth titc even	ToE	Steven Roark						Magg	ie D	insmare	Roar	k	
and I		19a. Informant's Name/Relations					,			I Route Numbe			Zip Code)
DESIGNOTOR, METYIERRO ZIZIO-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual content to publicate once.		Mark Elmore (S	Son)	200						ster, N			T Ct-t-
ges 1 it of He or oth		20a. Method of Disposition 1    1	3 Removal from	State	Place of Dispo cemetery, crei			1 _				tion - City or	
Saltimor  Sernit Pages Department of Important: If it Inty injury or or	١,	4 □Donation 5 □Other (S <sub>1</sub> 21. Sign ture of Funeral Service		Mot	unt Ros				/21/			Spring	g, VA al Home,Inc.
Dep Dep Day		21. Signature of Authoral Solvice	1 the	a land						ltvill			·
		23a. Part1. Enter the disease, or	complications that of	aused the dea									Approximate
Physician		shock, or heart failure. List fmmediate Cause (Final	only one cause on e	each line.		1	14-1	110		1. +	_		Interval Between Onset and Death
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OX OG D Certifica Sending ph Use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								230	d. Date of deli	ivery
death death	Icia	in the past 12 months? 1 □ Yes 2X No	4□Pregr	ointh 2 □ Fei nant at time of		⊒Ectopic pr ⊒ Other (sp						Month	Day Year
by the tache	hys	9 Unknown	9□ Unkn	own									
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w requires to been signer should be	ted									1	Yes 2 🔼	NO 3   PR	obably 4 Unknown
Has b	ompleted									24a. Was autoj		24b. Were au prior to (	stopsy findings available completion of cause of
icate	O									1 ☐ Yes	2 X No		2 🗆 No
VILAI iician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:		7500		Othe			Check only			
Phys r this eral di	. To	1 ☐ Yes 2 TNo 27. Manner of Death	1	Inpatient 2 [ of fnjury th, Day Year)	☐ ER/Outpatier 28b. Time o		8c. Injury Work	4 NU		me 5 Resi			city)
ding th.: Afte	# for	1 Naturat 5 ☐ Pendin 2 ☐ Accident investig	9	th, Day Year)	fn <del>j</del> ury	м		k? Yes 2□	No				
Attending at death.	ertification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 286. Place	of Injury - At I	home, farm, str	reet, factory	, office		- :	28f. Location (		vumber or Ru	ural Route Number,
safte Safte Ged in Bed in Ged	Cer		Dulla	g, oto. (opoo									
DIVISION OF VITAL INECT TO THE HARD TO THE HARD TO THE HARD WITHIN 24 hours after death.  To the Funeral Director: After this certificate has in completely filled in by the funeral director, page 2	edical	(Check only 2 Medical	g Physician: To the Examiner: On the b	asis of examin	nowledge, deat nation and/or in	h occurred vestigation	at the tim	n <i>e</i> , date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and pt	nd manner as lace, and due	s stated. to the cause(s)
the I	Med	one)  29b. Signaty and title of certifier	and man	ner stated.				e number				signed (Monti	
1 × 1 8		200. digitally and title of certifier	111 X	hil	1. 1		7	·7 \	4.1	2	21-	271.	7 ( 4 /
101		30. Name and address of person	who completed caus	e of death /lts	em 23a) (Type	Print)	1	~>	17	2	~ ( /		4006
4		Talm W. M	Adle	Fair 1	85 VO	1/4	RI	rad	V	Vestm		hair	MD 21157
Sta	ate	31. Date filed (Month, Day, Year)	BI .	legistrar's Sign	nature	0 1	1	· M. W.	1	CVICY!	4143 X1	Er J	, and
Regist	rar	MAR 0 3	2006	BUGA S	J. 190							-	

			1 - For State Registrar	State of Marylar		ent of Health and cate of Death	Mental Hygier	(UU0 )	06432
	Physici /Medio		Decedent's Name (First, Middle, Las GLORIA	A .	MCNEIL	L	2. Date of Death Month D	28 2006	3. Time of Death 01:30 AM
	Examir		4a. Facility Name (If not institution, give HAYUSOR HOSP			City, Town, or Location of Deat BALTIMORE		4c. County of Death	
	- Funeral Director		5. Social Security Number 6. S.  Usual Residence of Decedent	2 Age (In yrs.	Yrs. If U	nder 1 Year If Under 24 Hrs ths Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp Cour	place (State or Foreign
	ith the Maryland or 28a-f ahow	ctor	10a. State 10b. County	1 0c. Ci	ty, Town or Location	ORE		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23a or 20	Funeral Director	308 PAVISE	U ST.	101	21223	10g. (	Citizen of What Cour	ntry?
5-0036	72 hours after death with the Maryland naturel', or Iteme 23a or 28e-f ahow disal Esanta wr must be indiffied at	Ď	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 (\$\frac{1}{2} \text{NO} ) If Yes, Give Year or Dates:	If Yes,	ecedent of Hispanic Origin? (specify Cuban, Mexican, Puer as 2 Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0	- 1 70	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give kind o	Usual Occupation f work done during most of wo DT use retired)	rking 16b.	Kind of Business/In	dustry
and	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last)	Down		18. Mother's Na BUL	me (First, Middle, Maide	en Sulmame) GUIRE	
, Maryl	1 and 2 sho Health and I em 27 le me ther traums		BRENDA ME	URIL	308 /	ress (Street and Number or R	BALTO	MD. 21	723
Baltimore	0 0		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposition cemetery, crematory	(Name of or other place)  WEM	Date 2 200.	Location - City or To	own, State
Balt	permit. Pag Department Important: I any Injury o		21. Sonature of uneral Service Licen	Sparke h.	SKA	e and Address of Facility	2829 HUDS	9 NST 10 217	324
	Physician /Medical		23a. Part1. Enter the disease or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a END -STA	GE REA				Approximate Interval Between Onset and Death
- W	Examiner	-G	Sequentially list conditions, if any leading to immediate	h HYPOTENT  Due to (or as a consecutive of the cons	10N				7 DAYS
8760,	ate be executed hysician and he burial-transit	cal Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. MULTI- C Due to (or as a consect	ORGAN F	AILURE			
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3□Ectop	oic pregnancy r (specify)		23d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions of	ontributing to death but not re	sulting in the underly	ing cause given in Part I.	23e. Did tobacci	o use contribute to the	
of Vital Records,		Completed by	25. Was case referred to medical				24a. Was an autopsy performed 1 Yes 2 1	prior to co death?	psy findings available mpletion of cause of 2 No
f Vit	Physicia this certi al directo	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	Cthor	ath <i>(Check only one)</i> Home 5 - Residence	6 ☐Other (Specif	iy)
ion o	Attending Physician: r death. ector: After this certifica by the funeral director. p		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division	i Ditte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fa	ctory, office	28f. Location (Street City or Town, Sta		al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	ysician: To the best of my kn iiner: On the basis of examin and manner stated.	owledge, death occu ation and/or investiga	rred at the time, date and placation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier DR.	TARZHENSKY	МЭ	29c. License number		Date signed (Month, BRUARY 2	
/	3		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print) 3001 S	RES GOO HANOVERS	T BALTIME	ORE MID	21225
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 0 3 70	32 Registrar's Sign					

			1 - For State Registrar	State of I	Marylan		rtment of H		Mental Hyg	giene	06	06	433
			Decedent's Name (First, Middle						2. Date of Dea Month		Year	3. Time	of Death
	Physici /Medio		Sydney Linder	man McClell	and				March	1,		5:52	A M
	Examir	ner	4a. Facility Name (If not institution	n, give street and numb	er)		4b. City, Town, or	Location of Dea	th		nty of Death		
			Greater Baltimo				Towson	If I to doe 24 Her			imore		
	Funeral		5. Social Security Number 214-30-5354	6. Sex 7. 1 ☐ M 2 1 ☐ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1 Q 3/2	, Cou	ntr <u>y</u> )	e or Foreign
ı	Director		Usual Residence of Decedent		, _				03/20/	1900	New	Jerse	еу
	ylano how		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside	City Limits
	a-fal	cto	Maryland Balt	imore	Ti	moniun	1					1 □ Ye	es 2 X No
	death with the Maryland me 23a or 28a-f ehow Emust be notified at	Director	10e. Street and Number				10f. Zip Code			l0g. Citizen o	f What Cou	ntry?	
	23a		33 Dublin Driv	e			2109	3			USA		
	er de:	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	S. 13. V	Vas Decedent of H Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. R	ace - Ameri lack, White,		
96	s afte	by F	1 ☐ Never Married 2 ☐ Marr 3 🌠 Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2   If Yes, Give Year or Date	• •	1	☐ Yes 2 X No	Specify:		Spec	cify:	White	
5	P P P P P P P P P P P P P P P P P P P	edt	15. Deceden		13.	16a, Deced	ent's Usual Occup	ation		16b. Kind of	Business/Ir	dustry	
15	Media	plet	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4)	or 5+)	(Give	kind of work done of NOT use retired	furing most of wo )	orking				
21,	giene giene	Completed	12	Outage (194)	01 37)	Home	emaker			Own Ho	ome		
٠ ۲	al Hy al Hy Nent	Be	17. Father's Name (First, Middle,						me (First, Middle,				
- S	Ment Ment arked	To	Stuart Henry	Linderman				Mary	Kathryn	Neidi	ch		
0	2 sh and Is m	15	19a. Informant's Name/Relations				-		Rural Route Number			′	
U	C, I		Kathryn M. Boja 20a. Method of Disposition	nowski (dau					nonium, Ma	ary I and			
Sydney Sydney	politication of the first product of the first political political political political permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Hygiene.  Department of Hygiene.		1 ☐ Burial 2 🛣 Cxemation	3 Removal from Sta			sition (Name of natory or other place				•		a d
5,1	it. Partant		4 Donation 5 Other (S		1 11		Svc. Corp  Name and Addres		/03/06		on, Ma		
G	Depa Impo		My Da	Stephen	Coster				Ruck Town			-	, Inc.
9			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	sed the death h line.	. Do not ente	er the mode of dyin	g, such as cardia	ic or respiratory arr	est,		Approxim Interval B	etween
	Physician		Immediate Cause (Final disease or condition	a Ca	rdia	1	ark t	home				Onset and	d Death
0	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):	1'						
-		-	Sequentially list conditions,	b	as a consequ								
5 '	7 be as	Examiner	Sequentially list conditions, it any, trauming to initiodiata cause. Enter Underlying Cause (Disease or injury	200 10 (0)	as a consequ	enes ory:							
0 6	xecul n and	xan	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ence of):							
mecle	icate be executed physicien and sthe burial-transit	dlcal E											
C 0	ificate g phy	edlo		0.									
, S	Attanding Physician: The law requires that the death certific rideath.  To death.  Sector: After this certificate has been signed by the attending put the funeral director, page 2 should be detached for use as	Completed by Physician/Me	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor						23d. C	ate of deliv	ery	
α	se death the atte	Icla	in the past 12 months?	4☐Pregnant	n 2 □ Fetal tat time of de		Ectopic pregnancy Other (specify)			N.	onth	Day	Year
0	that the dead by the detached	hys	9 Unknown	9□ Unknowr									
of Vital Becords D.O.	es tha igned be de	by	Part fl. Other significant condition	ns contributing to death	h but not resu	Iting in the un	derlying cause give	en in Part I.		bacco use co			f death?
7	w require	ted	Jumm	^					1 🗆 Ye	es 2□No	3 ☐ Prot	oably 4	Onknown
2	e law r has be	ple							24a. Was a autops	n 24b	. Were auto	psy finding	s available
α	ysician: The I is certificete ha director, page	Con							perform	ned?	death?		
; ;	vician: Th	Be	25. Was case referred to medical examiner?	11					ath  Check only on	(e)			
	Physi this c	5	1 Yes 2 No	Hospital: 1 Inpa	-	R/Outpatient		4 Linursing i	Home 5 ☐ Reside			ý)	
( )	Jing Alter funer	io io	27. Manner of Death  1 □ Natural 5 □ Pendin	9	Day Year)	28b. Time of Injury	28c. Injury Work	at ? ∕es 2 ∐No	28d. Describe ho	ow injury occi	urred		
1	ttan death ctor: / the	Icat	2 Accident investig	not be	Injury - At hor	me farm stre	eet, factory, office		28f. Location (St	treet and Num	nher or Pur	al Pouta Nu	mhos
ج ب	after Dire	Certification:	4 ☐ Homicide determ	building,	etc. (Specify	)	et, factory, office		City or Town	n, State)	ibbi or mare	II HOULE IVU	iniper,
	To the Hospital or Attanding Phywithin 24 hours after death, to the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the be Examiner: On the basis	est of my know	vledge, death	occurred at the tim	e, date and plac	e, and due to the ca	ause(s) and r	nanner as s	tated.	
	the H	Medical	one)  29b. Signature and title of certifier	and manner	stated.		29c. License						
	S tay of		D / ////// ///	~ mo			250. Elbertse	573/	2	9d. Date sign	In!	Jay, 18ar)	
			30. Name and address of person			220) /T	Print\			3/2	106		
l	10		William V	M. Zula	o death (item	/a A	nc f	N	Do. 1	1.20	ms	21	2-11-1
					- 40 /		V.	- 13		70~1		, , ,	-00

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	=		1 - For State Registrar	State of M		Department Certificate	of Health	and Me	ntal Hygi	ene 0 6	06434
	Physici /Medi		1. Decedent's Name (First, Middle Clare Marie Min	nderlein				F	Date of Death Month EBAUAR	Day Year	10:50PM
	Examir Funeral	ier	4a. Facility Name (If not institution  GREATER BAL  5. Social Security Number	TIMORE MES		thday) If Under 1	Year If Unde	ISON	. Date of Birth		thplace (State or Foreign ountry)
	Director		N/A Usual Residence of Decedent 10a, State 10b, County	1□ M 2XXF	10c. City, Tow	Yrs.	Days Hours	Min. 35 F	eb. 15,	2006 Mar	yland
	death with the Maryland ms 23a or 28a-f show mast be notified at	rector	Maryland N/A  10e. Street and Number		Baltimo		Code		100	g. Citizen of What C	10d. Inside City Limits  XXYes 2 □ No
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumetic avent. It a Medical Eur. it with mast be rigitlised any once.	Funeral Director	1517 Byrd Stree	12. Was Decedent Armed Forces?		212	30 ent of Hispanic C fy Cuban, Mexic		U1 0:	nited Sta f America 14. Race - Am Black, Wh	tes erican Indian,
21215-0036	within 72 hours after ene. than "natural", or Ita	Completed by	3 Widowed 4 Divorced  15. Deceden (Specify only highe Elementary/Secondary (0-12)	Year or Dates:		Decedent's Usual (Give kind of work life. DO NOT use	Occupation		16	Specify: Whi	
	uld be filed wi Aental Hygien rkad othar th tic avant, the	To Be Con	0 17. Father's Name (First, Middle, Jeffrey Paul M	·		Never	18. Mot		First, Middle, Ma		-
e, Maryland	1 and 2 shou Health and N Im 27 is ma Thar traume		19a. Informant's Name/Relations  Jeffrey P. Mino  20a. Method of Disposition		her) 151	_	treet;		more, Ma	City or Town, State, aryland 2	1230
Baltimore,	mit. Pages bartment of h oortent: If its r injury or of		XXBurial 2 □ cremation  4 □ Donation 5 □ Other (S		cemeter	y, crematory or oth Park Cen	netery	Feb. 2 2006	21, Ba	altimore. Funeral H	Maryland
B	Dermi Depa Impo any ir		shock, or heart failure. List	complications that caused only one cause on each lie	I the death. Do r			3620 Balti	wilkens more, M	Avenue aryland 2	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	a consequence	rematu of):	uty				Chist and Death
	ecuted and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause loisease or injury that initiated events resulting in death) Last	с.	a consequence of						
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.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 □Ectopic prec 5 □ Other (spec				23d. Date of de Month	livery Day Year
Records, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant condition	ns contributing to death b	ut not resulting in	the underlying cau	use given in Parl	· I.		_	o the cause of death?
tal Reco		e Completed	25. Was case referred to medical						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
n of Vital	ing Physicien:  After this certifications of the control of the co	To B	examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pendin	Hospital: 1 Inpatie				lursing Home	5 Residence Describe how	ce 6 Other (Spe	rcify)
Division		Certification;	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	ation ot be	ury - At home, far c. (Specify)	m, street, factory,	1 ☐ Yes 2 ☐		Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospital or Attano within 24 hours after death To the Funeral Diractor: completely filled in by the	Medica C	(Check only 2 Medical one)	g Physicien: To the best of exeminer: On the basis of and manner sta	examination and	for investigation, in	n my opinion, de	eath occurred	at the time, date	and place, and du	e to the cause(s)
)	To To Corm	2	29b. Signature and title of certifier	V. He	ngon	- MD	License number			Date signed (Mon	
	Sta	te	30. Name and address of person 31. Date filed (Month, Day, Year)	CHIRLE ST	eath (Item 23a) ( T ar's Signature	erication in the second	Mayen	6 2/20	<i>†</i>		
	Registr	ar	MAR 0	2006	But Att	Janks.					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Peter Van Cortlandt Moore 02 27 04:50pM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4974 Sentinel Dr. #206 Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **3**€M 2 □ F 86 481-48-3560 Director Yrs. 07-25-1919 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4974 Sentinel Dr. #206 20816 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 → Yes 2 → No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) 5+ Elementary/Secondary (0-12) Hygiene. Physician Medical 27 is marked other treumatic event, permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth eny jury or other treumatic event 20cs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barrington Moore Muriel Morris ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pamela H. Moore/wife 4974 Sentinel Dr. #206 Bethesda MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 03-01-2006 Beltsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 ma1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw EMPHYSIEM 7 Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Qualto (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, physicien Certification: To Be Completed by Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) should be detached signed by the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALFERIOS (LEROPTIC C) PEDIO (1) SCOLAR DISCOSS 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown реец 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan has page 2 certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No To the Hospital or Attending Physical 24 hours elter death.

To the Funeral Director: After this completely filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ∰Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 152 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signaturé/and title of certifier 29c. License number 8b 29d. Date signed (Month, Day, Year) Fel 28 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jerry Snow 4900 Massachusetts Av NW #300 Washington DC 20016 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death FEBRUARY Day **Physician** 28, ŽŽ06 MARVIN C. MOORE 4:15 AM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore Months Days Hours Min. 8. Date of Birth Month, Day Year) 5/24/1927 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Director 78 VIRGINIA 231-24-3158 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-1 ehow rthan "natural", or items 23a or 28a-f ehovite Medical Examiner must be notified at MD BALTIMORE PARKVILLE 1 ☐ Yes 2 X No Direct 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1524 DAYTONA ROAD 21234 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 X) Yes 2 New II If Yes, Give WWII Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 M Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST BAXTER-TRAVANAUGH 10TH GRADE is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ould be f Mental I RALPH MOORE FLOSSIE KING and ! 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau KIMBERLY CARTER/DAUGHTER 8119 DALESFORD ROAD PARKVILLE, MD 21234 Baltimore, 20b. Place of Disposition (Name of DUCANEY COVAPLE THE MEN) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS 4 ☐ Donation 5 ☐ Other (Specify) 3/4/2006 COCKEYSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD dart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of): physician a s the burial-Physician/Medical as attending p IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetat death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 Other (specify) ed by the o 9 Unknown 9 Unknown ۵. signed b Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown cate hes been sig , page 2 should b 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Division of Vital 2 X No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Da e of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Injury 1 Natural 5 Pending efter death.

f Director: Af
d in by the fur м 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) ŏ To the Hospitel or within 24 hours eft To the Funeral Di 1 Certifying Physician: To the best of my Ryowle 2 Medical Examiner: On the basis of examination and manner stafed. 29a, Certifier Medical owledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D 42736 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AYMAN FATHI <u> AKHAD</u> M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State A DESCRIPTION OF THE PARTY OF T Registrar

Amend item/8,18,19b, perill, 0853,3/15/06 II State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Kathleen Α. 5:07 AM Nichols Feb.21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8337 Liberty Road Wood Lawn I Under 1 Year II Under 24 Hrs. Baltimore 8. Date of Birth July (Year)
May 7, 19 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2√2 F Min. 214-14-2808 Director 90 S. Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Modical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes X☐ No Woodlawn Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #E1 2002 Woodlawn Drive 21207 USA Completed by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamstress 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Abraham Alexander Adla Ada ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3337 Liberty Road Woodlawn Md. 21207 2002 Woodlawn Dr. #El Lucille Smith 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Wood Tawn Cemetery 2/25/06 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Md 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligersee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 aus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9-2002 **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ w 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) မှ 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 [Natoral 1 ☐ Yes 2 ☐ No 2 Accident M 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide To the Hospitei o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 06 0, 30. Name and address of person who completed cause of death (Item 23a) (Type Print) G/6000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Registrar

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F		-	giene	06439
	*		Decedent's Name (First, Middle	o, Last)				2. Date of Dea	ith	3. Time of Death
	Physic /Medi		Losee		J.	Ne1s	ion.	Wanth	Day 2000	0 11:00 P.M.
	Exami		4a. Facility Name (If not institution	, give street and numb	per)		r Location of Dea	th	4c. County of Dea	th
			Baltimore Wash			Glen	Burnie		Anne A	rundel
ч	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday	Months Days	If Under 24 Hrs Hours Min		y, Year) 9. Bii	thplace (State or Foreign ountry)
	Director		234-26-9751 Usual Residence of Decedent		92 Yrs.			Dec. 2:		st Virginia
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show iteal Examiner must be notified at		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, Itte Madical Examiner must be notified at ances.	ţō	Maryland Anne	Arundel	Glen Bu	rnio				1 ☐ Yes 2 No
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			23a. Party. Enter the disease, or	complications that cau	sed the death. Do not en	8204 Mount	tain Road	d Pasaden	a, Marylan	d 21122 Approximate
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Вох	death certifics e attending ph id for use as tl	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		7			23d. Date of de	ivery
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E	/Medic Examin		4a. Facility Name (If not institution, give :			4b. City, Town,	or Location of	Death	-bigara	40	2006 County of Dea	
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	99fh	era		12. Was Decedent Ever in U.S	5 13 1			in? (Speed	y Yos or No		14. Race - Ame	riogo India-
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if time X7 is marked other than "natural", or itema 23a or 28a-f show eny injury or other traumatic event, I a Mudical Examinar must be notified at once.	Completed by Funeral Director	1 Never Married 3 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes /2/ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cui		Puerto Rio	an, etc.)		Black, Whit	
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Maryland	of 2 shoulth and A		19a. Informant's Name/Relationship (Ty) Mojisola K. Odusan		19b. Mailin 5020	g Address (Stree	t and Number	or Rural F	loute Numbe	r, City	or Town, State, 2	Zip Code) 1206
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Baltir	permit. P Departme Importar eny injur		21. Signature of Funeral Service License	98		ASSAN Add						
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			23a Part 1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final	e cause on each line.	. CO NOT BITTE	or the mode or dy	ing, such as ca	ardiac or re	espiratory an	rest,		Approximate Interval Between Onset and Death
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6	V	-	30. Name and address of person who cor	npleted cause of death (Item :	23a) (Type, F		, , ,			CUY	1014 20	0,2006
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			Cardyce DeLoatel 31. Date filed (Month, Day, Year) MAR 0 3 200	4940 East			tunon	e, N	1D 21	22	4	

			1- For State Registrar	te of Maryland		artment of h			giene 006	06441
1	<b>克 罗杰</b> 士	施	Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physici /Medio		William Fre	derick Ocon	is			Month Februa:	Day Yea	
	Examir		4a. Facility Name (If not institution, give street a	and number)		4b. City, Town, o	r Location of De	eath	4c. County of De	eath
2			Eastpoint Rehab & Nur	sing Center			tpoint		Baltin	more Co.
	Funeral		5. Social Security Number 6. Sex 194-24-9224 1∑ M 2	7. Age (In yrs. ias		If Under 1 Year Months Days		Irs. 8. Date of Birth (Month, Day	9. E	Birthplace (State or Foreign Country)
46	Director			73	Yrs.			Aug. 8	77	ennsylvania
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Fown or Lo	cation				10d. Inside City Limits
	Many f ehc	ō	Maryland Baltim					Edger	mere	1 ☐ Yes 2⁄XXNo
	the 286	Pec	10e. Street and Number			10f. Zip Code			0g. Citizen of What	Country?
	3a or	<u></u>	2825 Lodge Farm Road	Apt. 401			2121		United S	,
	ms 2	era		s Decedent Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin?	(Specify Yes or No-		mencan Indian,
9	or Ite	F	1 Never Married 27 Married 1	ned Forces? ]Yes_2⊠No		f Yes, specify Cuba		erto Rican, etc.)	Black, W	hite, etc.
93	72 hours after death with the Maryland naturel', or Items 23s or 28e-f ehow dical Exantrar must ke notified at	p	3 ☐ Widowed 4 ☐ Divorced Ye	es, Give ar or Dates:		I□Yes 2Ã No	Specify:		Specify:	White
21215-0036	72 h	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade comp	eleted)	(Give	lent's Usual Occup	during most of v	working	16b. Kind of Busine	ss/industry
12	vithin ne. hen	mp	Elementary/Secondary (0-12) Co	lege (1-4or 5+)		OO NOT use retired	OWII			
7	Hygie Hygie ther i		12 Years 17. Father's Name (First, Middle, Last)		Tr	uck Driv		rator	Trucking	<u> </u>
and	od be	Be	,					_	,	
Maryland	hould Me Id	ို	William Oconis  19a. Informant's Name/Relationship (Type, Pri	nt)	10h Mailin	a Address (Street		Clara Kand Rumal Route Number		Zin Codel
Z	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Exercities invasible multilized at		Mary J. Oconis (Wife			Lodge F				ere, MD 21219
Baltimore,	s 1 and 2 of Health a Item 27 Is		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of		-	20c. Location - City	
E O	Page ento nt: If ry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova 4 ☐ Donation  5 ☐ Other (Specify)	i from State	•	natory or other place Service (	. 1	/2/2006	Towcon	Marriand
Ħ	permit. Pages I Department of H Importent: If Ite any injury or ot Once.		21. Signatur Juneral Service Licensee		22	. Name and Addres	ss of Facility			Maryland
m	Depa Impo any i		Caredon C.	Keen	_ D	uda-Ruck	Funera	l Home of Dundalk, M	Dundalk,	Inc.
			23a. Part1. Enter the disease, or complications shock, or head ailure liet only one caus	that caused the death.	Do not ente	er the mode of dyin	ig, such as card	liac or respiratory arr	est,	Approximate Interval Between
·	Physician			erebros	asci	las a	ccido	-t		Onset and Death
	/Medical		resulting in death)	ue to (or as a consequer						702
Ž,	Examiner		Sequentially list conditions b. —							
and and	od sit	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequer	co of).					
10	and I-tran	Examiner	that initiated events	ue to (or as a consequer	ica of):					
760,	ate be executed hysicien and the burial-transit	Ical E		20 10 (01 23 2 0011504201	100 01).					
687	ficate phys s the		d							
Box	certii nding use a	Ž.	IF FEMALE: 23b. Was decedent pregnant 23c. If y	es, outcome of pregnancy	,				23d. Date of d	leliven
ă	death a atte d for	clai	in the past 12 months?	Live birth 2 Fetal de Pregnant at time of deat		Ectopic pregnancy Other (specify)			Month	Day Year
P. O.	t the by the ache	Physician/Med	9 □ Unknown 9□	Unknown						
	res that the death certifica igned by the attending pl be detached for use as t	by P	Part II. Other significant conditions contribution		ng in the un	derlying cause give	en in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
Records,	w require been sig		Sicial deub	itus				1 □ Ye	s 2 □ No 3 🕱	Probably 4 Unknown
ပို့	law re as be 2 sh	ple						24a. Was a	n 24b. Were	autopsy findings available o completion of cause of
	rsicien: The law s certificate has b director, page 2 s	Completed						- autops perforr 1 ☐ Yes 2	ned? death'	?
/ita	cien: ertific ector,	Be (	25. Was case referred to medical examiner?				26. Place of D	eath (Check only on		
7	Physi this c	2	1 ☐ Yes 2 No Hospital	1 Inpatient 2 LER		3□ DOA Oth	4 Nursing	Home 5 ☐ Reside	nce 6 □Other (Sp	ecify)
Division of Vital	ding F	lon		Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injun Work		28d. Describe ho	w injury occurred	
Sic	uttendi death. ctor: A y the fu	Icat	2 Accident investigation 3 Suicide 6 Could not be	Diago of Injury At home			Yes 2 No	001 1 (01		
2	or A after Direction by	Certification:	4 Homicide determined 289.	Place of Injury - At home building, etc. (Specify)	, raim, stre	et, ractory, office		City or Town	reet and Number or I n, State)	Rural Route Number,
Τ,	Hospitel or Attending Physicien: The law requires that the death certificate be executed 24 hours after death. 2 Enterel Directors. After this certificate has been signed by the attending physicien and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physician:	To the best of my knowle	dge, death	occurred at the tim	ne date and ola	ce and due to the ca	use(s) and manner	as stated
	To the Hospitel or Attenwithin 24 hours after dealt To the Funerel Director: completely filled in by the	Medical	2 Inedical Examiner: Ur	the basis of examination manner stated.	and/or inv	estigation, in my or	pinion, death oc	curred at the time, da	ate and place, and di	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	e number	25	9d. Date signed (Mo	nth, Day, Year)
			matter K	nololore	X	D4	575	7 /	March	1, 2006
	1		30. Name and address of person who complete	d cause of death (Item 23	a) (Type, F	Print)		-		0 21224
			Mattlew MCN2	sney 4	940	8 254	ern d	heme	Balt M	0 21224
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 3 2006	32 Registrar's Signature	Are	de				

				State of Mar			lealth and Me	•		00110
	_			1 - For State Of Wal	Cer	tificate of		Reg	No. UUD	06442
7.	ı	Physici /Medio		1. Decedent's Name (First, Middle, Last) Margaret J. Pecora				2. Date of Death Month	Day Year 27, 200	3. Time of Death 2045 M
		Examin		4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Cer	nter	4b. City, Town, o Be1	r Location of Death Air		4c. County of Death	1
		Funeral Director		1 M 2 F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	nplace (State or Foreign untry)
	2	D.		218-14-2398 x 86  Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	nation.		Nov. 29,	1919 Ma	ryland  10d. Inside City Limits
		Maryla a-f sho	tor	Md. Harford	•	ldwin				1 ☐ Yes 2X☐ No
10		death with the Maryland rme 23a or 28a-f show rmatte neillfed at	i Director	10e. Street and Number 2706 Greene Road		10f. Zip Code 21	013	10g	Citizen of What Co	untry?
3045	980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show eny figury or other traumatic event, the Modical Examination in colling of any figury or other traumatic event, the Modical Examination of the notified at ange.	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: W	
•	215-0036	hin 72 ho s. na natur Modical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give i	ent's Usual Occup kind of work done o OO NDT use retired	eation during most of working d)	g 16	b. Kind of Business/l	ndustry
70	2121	ed wit	Соп	8 years		tician			air salon	
90/Le/	and	ld be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last)  John Shoemaker			18. Mother's Name Ellen T.		iden Sumame)	
7	Maryland	2 shour and M Is mar	-	19a. Informant's Name/Relationship (Type, Print)		_	and Number or Rural	Route Number, C	-	ip Code)
0		1 and Health em 27		Joseph Pecora/husband  20a. Method of Disposition	20b. Place of Dispos				c. Location - City or	Town, State
	Baltimore	Pages nent of ant: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Bayview C				altimore,	
	Balt	permit. Departr Importa eny inj		21. Signature of Funeral Service Licensee			ss of Facility Funeral H			
9				23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	10 W. Ma er the mode of dyin	.cPhail Roa ng, such as cardiac or	td, Bel A respiratory arrest	ir, Md. 2	Approximate Interval Between
3		Physician				nock				Onset and Death
3		/Medical Examiner		Due to (or as a	Septic S consequence of): Preumo	noia.				
Y	y	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	conseque ice of).	N. W.				
to to	68760,	cate be executed oblysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a of d.	consequence of):					
gar	.O. Box 6	it the death certifical by the attending phi tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
3	s, P	quires that n signed b	by Pi	Part II. Other significant conditions contributing to death but	-	derlying cause giv	en in Part I.		co use contribute to	
5	cord	v requir	eted	Probable Whenic (4)				1 Yes		bably 4 Unknown
	Rec	: The law cate has	ompleted	Coronary array dis		wo (Ared)	ial infaro	24a. Was an autopsy performe	prior to death?	topsy findings available ompletion of cause of
Z	la.	ysician: is certifica directo , p	Be C	25. Was case referred to medical examiner?	euse !!		26. Place of Death	Check only one)		
0	of V	d is	٦.	1 Yes 2 No Hospital: 1 Impatient	2 ER/Outpatient		er: 4 Nursing Hom			ufy)
7			ation	27. Manner of Death  1 Natural 5 Pending (Month, Day )  2 Accident investigation	rear) Injury	28c. Injun World M 1 [	yat k? Yes 2 □No	3d. Describe how	injury occurred	
9	Division	al or Attence after death Director: d in by the	Certification:	2 Could not be	/ - At home, farm, stre (Specify)	eet, factory, office	28	3f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
		To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of 2 Medical Exeminer: On the basis of e and manner state	xamination and/or inv	occurred at the tin estigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
		To the within To the complex	Me	29b. Signature and title of certifier		29c. Licensi			Date signed (Month	
	•	2		· Cusastul	Ab //a = 00 \ T	De	063420	F	ebruary!	27,2006
		)		30. Name and address of person who completed cause of dea Zubair Siddiq	500 Upc	zer Ches	appako	Drive-	Beldir 1	27,2006 NO 21014
	400	Sta		31. Date filed (Month, Day, Year) 32. Registrar:	s Signature	will !	7		,	

			1- For State of Maryland / De Registrer	partment of Health and Me ertificate of Death	ental Hygiene 006 06443
I	Physici /Medi		Decedent's Name (First, Middle, Last)     Carl DeWitt Porter		2. Date of Death Month Day Year  02- 26-2006 6:30 PM
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number)  5. Social Security Number  177-16-8489  4a. Facility Name (If not institution, give street and number)  7. Age (In yrs. last birthd)  7. Age (In yrs. last birthd)	4b. City Town, or Location of Death  DSCOCO  ay) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)
	D D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or		Oct. 31,1921   Pennsylvania
	h the Mar r 28a-f si Lnotified	Director	Maryland Baltimore  10e. Street and Number	Dundalk 10f. Zip Code	1 ☐ Yes 2 【No
	th with		2613 Ambler Road	21222	United States
036	n 72 hours after death with the Maryland "natural", or Itame 23a or 28a-1 show adical Examinar must be notified at	by Funeral		3. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes 2 ☐ Specify:	ify Yes or No- ican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:
215-0036	72	Completed	15. Decedent's Education (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working b. DO NOT use retired)	White 16b. Kind of Business/Industry
7	filed within Hygiene. ther then "	Com	12 Years	Truck Driver	Steel Industry
yland	e a a e	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)
<u> </u>	should and Men marke umatic	To	Frederick Porter  19a. Informant's Name/Relationship (Type, Print)  19b. Ma		ce DeWitt  Route Number, City or Town, State, Zip Code)
Ma	nd 2 alth a 27 is				way Silver Spring, MD 20901
e e	pes 1 a of Hea of Item of othe		20a. Method of Disposition 1   20b. Place of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition ceretery, or	position (Name of Parematory or other place)	te 20c. Location - City or Town, State
partimo	t. Pages tment of tant: If It		4 □Donation 5 □Other (Specify) Gardens	of Faith Cem. 3/2/2	2006 Baltimore, Maryland
<u> </u>	permit. Pages Department of Important: If II eny Injury or o		Melet a poner	7922 Wise Ave. Dund	ome of Dundalk, Inc. alk, Maryland 21222
,	Physician /Medical		23a Fart 1. Enter the disease or complications that caused the death. Do not a shock, or heart failine. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence ol):	onter the mode of dying, such as cardiac or	respiratory arrest, Approximate Interval Between Onset and Death
	cate be executed XB physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b		
	in to propriator furthering prysicien: The law requires that the death certifical his 24 hours after death.  The Funeral Director: After this certificate has been signed by the ettending phy pletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi		B⊟Ectopic pregnancy G⊟ Other (specify)	23d. Date of delivery Month Day Year
, cp.,	equires thaten signed I	۵	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Nown
י ובכר	i: Ine law ricete has be	Completed			24a. Was an autopsy autopsy findings available prior to completion of cause of death?  1 Yes 2 No
	sicier certif irecto	o Be	25. Was case referred to medical examiner 1 — Yes 2 No Hospital: 1 I Innatient 2 — ER/Outpate	26. Place of Death (cont. 3 Dogs. Other.	
5 7	er this	⊢⊦	27. Manger of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28c	5 Residence 6 Other (Specify)  d. Describe how injury occurred
5 :	aath. or; After he funer	atlo	1° ☑ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
	of the nospital of Attention within 24 hours after death.  To the Funerel Director; A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		f. Location (Street and Number or Rural Route Number, City or Town, State)
	within 24 hours and the Funeral I completely filled	Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
i	within To th	Me	29b. Signature and title of certifier  Almotainy Eid	29c. License number RESOOOD	29d. Date signed (Month, Day, Year)
(			30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	
2	T		Dr. F. d Almytainy 9000 Frank 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ilin Square Drive	Baltimore Mu. 21237
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	east &	- t

State of Maryland / Department of Health and Mental Hygiene For Stete Registre Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 24 Year **Physician** FEB 6:35 PM Virginia Alice Parr 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GOOD SAMARITAN HOSPITAL RALTI MORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2⋤ F 85 Yrs. 220-07-4402 Nov. 12,1920 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1XXYes 2 □ No Baltimore City Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21213 United States "natural", or Items 23a 3679 Kenyon Ave. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 28 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Years 17. Father's Name (First, Middle, Last) []kn. 18. Mother's Name (First, Middle, Maiden Sumame) Be Cook McBride 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If item 27 is m eny injury or other traum QDCs. 7325 Geise Ave. Edgemere, Maryland Mr. Leonard C. Parr (Son) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns. 2/27/2006 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenseen 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland ones Part1. Enter the disease, optomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS ASPIRATION PNEUMONIA Physician disease or condition resulting in death) /Medical Examiner OBSTRUCTIVE PULMONARY CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No B Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 No 1 Tes 212 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No | Director: A investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours after To the Funerel Dire the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. RES 000 FEB, 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL , BALTIMORE , MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 3 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year BERNADETTE M. PLAMONDON February 27, рМ 2006 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death **Examiner** 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ xF Yrs. Director 4/17/1948 215-56-4628 MARYLAND Usual Residence of Decedent 10a. Sfafe 10h Counts 10c. City. Town or Location 10d. Inside City Limits or items 23s or 28s-f ehov the Medical Examiner must be notified at Funeral Director MD BALTIMORE PERRY HALL 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 COATSBRIDGE COURT 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marifaf Sfatus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 Widowed 4 Divorced ff Yes, Give Year or Dates: Specify: WHITE neturei Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then. Efementary/Secondary (0-12) Colfege (1-4or 5+) DIETICIAN MD MASONIC HOME 11TH GRADE other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental H GEORGE GODWIN 2 UNAVATLABLE DOROTHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other treu AMANDA E. PLAMONDON/DAUGHTER 2608 WYCLIFFE ROAD BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 3/1/2006 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between On at and Death Immediate Cause (Final disease or condition resulting in death) Wer **Physician** allure /Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, Physician/Medical Vanama IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached f of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed 20 No 1 Yes 2 2 100 To the Hospitel or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Many r of Death 1 V atural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending death. investigation 2 Accident 1 Yes 2 No efter death 6 Could not be determined 3 🗀 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 060460 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

State Registrar DHMH 17 Rev 1/2001

MAR 0 3 2006

31. Date filed (Month, Day, Year)

VC

32 Registrar's Signature

11			1 - For State Registrar	State of Maryland / D		rtment of H tificate of L			giene Reg. No.	06	06446
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month Februa	Day	<b>,</b> 2006	3. Time of Death 6:40 P M
	/Medic Examin	al	OWEN JAMES QUEEN  4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of De			unty of Death	0:40 P M
			1621 Lorimer Road			Glen Bu			1	e Arund	
П	Funeral Director		5. Social Security Number 6. Sex 1 ☑ 6. Sex	N 005 30	rday) rs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		th 17, Year) 2, 193	9. Birthp Cour 2 WEST	place (State or Foreign otry) VIRGINIA
	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Loc	ation				1	0d. Inside City Limits
	a-fah	ctor	MARYLAND ANNE ARUN	NDEL GLEN BU	RNI	E					1 ☐ Yes 2 No
	with the	Funeral Director	10e. Street and Number 1621 LORIMER DRIVE	7		10f. Zip Code 21061			-	of What Cour	•
	death ms 23	nerai		12 Was Decedent Ever in U.S.	13. W	_L	spanic Origin?	(Specify Yes or No erto Rican, etc.)		D STATE	can Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Menlar Hygiene. If Health and Menlar Hygiene. Other traumatic avent, the Modical Examinar must be notified.	oy Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cubai  ☐ Yes 2 No	n, Mexican, Pui Specify:	erto Rican, etc.)		Black, White, ecify: WHI]	
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	be filed within ital Hygiene. d other than avent, the Me	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle			
10	should b nd Ment marked imatic a	10	HERCHEL JAMES QUEE  19a. Informant's Name/Relationship (Type		A 4 - 10 - 1	A 44 (Sharet		BLY BRADY		C	
Ma	nd 2 sl alth and 27 ia r r traur		JAMES A. QUEEN / S					Rura <i>l Route Numb</i> EN BURNIE			
ore,	pes 1 and 2 of Health if item 27 or other tr		20a. Method of Disposition  1 □ Burial 2 ☐ Cremation 3 □ Re	20b. Place of I	Dispos		e) FE	Date BRUARY		ion - City or To	
Baltimore,	permit. Pages 1 and Depertment of Healt Important: if item 2 any injury or other once.		4 ☐ nonation 5 ☐ Other (Specify)  21. Signalure of Noneral Service License	METRO	T.	MATORY,		7, 2006			MARYLAND
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	).						
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P.O.	0 0	Physician/M	1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□Unknown	5 🗌	Other (specify)				Month	Day Year
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Vita	ysicien: The is certificate he director, page	Be	25. Was case referred to medical examiner?	ospital:		all poa   Dthe	AC"	eath (Check only o			
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Div	af or At after of Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, fame building, etc. (Specify)		et, factory, office		28f. Location (S		umber or Rura	I Route Number,
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			Mari au	mica tolla	el.	MO OCME			'ebruai	ry 24.	2006
	Y		30 Name and address of person who cor	mpleted cause of death (Item 23a) (T			Street	, Baltimo		,	
ş	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	a se	. 14			-		

	thy Lee	Q		~			4 49 4 4-1	<b>-</b>				
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	with the	i Dire	10e. Street and Number 1621 LORIMER RD.				10f. Zip Code 21061				Citizen of What Cour FED STATE:	-
	me 2	ınera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes o	r No-	14. Race - Americ Black, White,	
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Baltimore, Maryland 21215-0036	be filed stal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last CHARLIE GREEN	)				18. Mother's Na			an Sumame)	
aryle	should nd Mer marke	To	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Street				or Town, State, Zip	Code)
Ž,	and 2 ealth a th 27 to		JAMES A. QUEEN /	SON				RD., GLI				
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	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer	Medical	29b. Signature and title of certifier	and manner sta	ited.		29c. Licen				ate signed (Month,	
	Wit.		Hote a	ionica-	Poll	Lo	OCME			Feb	ruary 24,	2006
-	Felban		30. Name and address of person who	- D	eath (Item	/				-		01665
	Ø ∜ Sta	te	31. Date filed (Month, Day, Year)	32. Region		MD		Street,	Balti	more,	Maryland	21201
	Registr		MAR 0 3	2005	Frito	As a	Grand.					

			1- For Amend Item#7 &	State of Marylar 8 per FH G85	nd / Depa 3 3/8/	artment of H CC <i>Tificate of L</i>	ealth and D <i>eath</i>	Mental Hy	giene	06	06448
4	Physici	an	1. Decedent's Name (First, Middle, Las	1)				2. Date of De		Year	3. Time of Death
	/Medic		ARTHUR C	ROSEBOROUGH				Februa		2006	7:30 p M
-	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or		ith	4c. C	ounty of Death	1
*	Funeral	<b>100</b> m	531 N BRICE STREE  5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	BALTI If Under 1 Year	MORE If Under 24 Hr		th <b>191</b> 0	N/A	Inlace /State or Foreign
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	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (	Specify Yes or No		Race - Amer	
36	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examirer must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No		Tes, specify cuba	Specify:	ito rican, etc.)	Si	8lack, White pec <i>ify:</i> BLA	
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골	should nd Men merke umatic	은	ARTHUR ROSEBORO					E LEE HOL			
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Ë	Pages nent of I nnt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	terrioval ironi State	RRISON	ratory or other place FOREST	1	-02-06	OWING	S MILL	S, MARYLAND
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۵.	res that the de signed by the a be detached f	y Ph	Part Other significant conditions co	ntributing to death but not resi	ulting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
Division of Vital Records,	quires n sign	ed by	1).	AcinomA					′es 2□N		pably 4 Munknown
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<del>_</del>	Physic this o	၉	1ÆPYes 2□No		ER/Outpatient		4   Nursing I	Home 5 Resid			(y)
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<u>s</u>	r Attendi er deeth. rector: A by the fu	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, stre		es 2 No	28f Location (S	Street and N	umber or Rus	al Route Number,
á	rs after el Dire ed in b	Certification;	4 Homicide determined	building, etc. (Specif)	y)			City or Tow	n, State)	umbor or rigit	ar riodio ivallibor,
	To the Hospital or Attendi within 24 hours after deeth. To the Funerel Director: A c-mpletely filled in by the to	edicai	29a. Certifier 1 Certifying Physical Examini	sician: To the best of my kno ner. On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my opi	e, date and place inion, death occi	e, and due to the ourred at the time, o	cause(s) and date and pla	d manner as s	tated.  o the cause(s)
	To the	Med	29b. Signature and title of certifier	with mainten stated.		29c. License				gned (Month,	
			Hollin W	Com	>	1/3	2040		3/2	-106	,
4	11		30. Name and address of person who co	empleted cause of death (Item		Print)	inc interes	. 60		100	
	1		21 Date filed (Month Day Year)			vet mi	w RI	w/Z			
	Stat Registra	7	31. Date filed (Month, Day, Year)  MAR 0 3 200	32. Registrar's Signa	ture	Car.					

			For State Ragistrar	tate of Maryland		artment rtificate			and M		giene Reg. No.	06	06449
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month		Year	3. Time of Death
	/Medic		Maggie Robinso			I				Month 02	28	06	4:40 A M
	Examin	er	4a. Facility Name (If not institution, give stree	•				Location o				ounty of Death	
	Funerai		Woodside Nursing C  5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under	1 Year	Sprir If Under 2	24 Hrs.	8. Date of Birt (Month, Day	h M	ontgome 9. Birthp	ry place (State or Foreign ptry)
Н	Director		577-24-8673 1□M	2⊠F 83	Yrs.	Months	Days	Hours	Min.	(Month, Da)			h Carolina
	pu *		Usual Residence of Decedent  10a, State 10b, County	10c City	Town or Lo	antina							0d. Inside City Limits
	Aaryla f sho	ō	D.C.		shing							'	1√ Yes 2 No
	28a-	rect	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Coun	ntry?
	h with	al D	7538 Morningside Dr	ive N.W.		20	0012					USA	
	ems	ner	11. Marital Status 12. V	Vas Decedent Ever in U.S Armed Forces?	. 13.				gin? (Spe	cify Yes or No- Rican, etc.)		Race - Americ Black, White,	
36	s afte	by Funeral Director	1 Never Married 2 Married 1	☐Yes 2∏No fYes, Give	ĺ	1 ☐ Yes 2		Specify:	,	,,		pecify: Blac	
Ö	hour ture!		3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Education	Year or Dates:	16a Dece	dent's Usua	I Occupa	ition				l of Business/Inc	
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7	ad with	Som		2 yrs.	Acc	counta	int _				U.S.	Govern	nment
pu	be file d oth event	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Si	umame)	
Z a	d Men narke natic	은	Monroe Miller  19a. Informant's Name/Relationship (Type, I	Dirinal	405 M-16		(0)	Le	na N	ix			
Maryland 21215-0036	id 2 sl Ith and 27 is r traur		Jessie Brown/Siste		1220	East	West	na Numbe t Higi	r or Hurai hwav	#909A	Silve	er Sprin	20910
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at anone.		20a. Method of Disposition	20b. Pla	ace of Dispo					ate		ition - City or To	
altimore,	Page: nent o nt: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	Valifori State	yland			1	3-6-0	06	Laure	1, MD.	
ä	permit. Departminporte		21. Signature of Funeral Service Licensee									ral Hom	ne
<u>m</u>	89 5 8		PMarshal	L								D.C. 20	0011
ī,			23a. Part 1/ Enter the disease, or complication shock, or heart failure. List only one car	ons that caused the death. nuse on each line.	Do not ent	er the mode	of dying	, such as	cardiac or	r respiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Sepsis									Onset and Death
П	/Medical Examiner		, obtaining in abality	Due to (or as a conseque Decubitus U									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ulsease or Injury	Due to (or as a conseque									
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9 X	eath certific attending p for use es	/Me	IF FEMALE: 23c. I	f yes, outcome of pregnance	cv						22	d. Date of delive	
Вох	death a atter d for u	clar	in the past 12 months?	Live birth 2 Fetal d	death 3	Ectopic pre Other (spe					236	d. Date of delive Month	Day Year
<u>о</u> .		hys	9 Unknown	9□ Unknown									
	se us	by P	Part II. Other significant conditions contribu	iting to death but not result	ting in the u	nderlying ca	inse åine	n in Part I.					e cause of death?
ord	w requir been si should	ted								1 U Y	es 2 🗆 i	No 3 ☐ Proba	ably 4 🛣 Unknown
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ō		$\vdash$	27. Manner of Death		28b. Time of		Bc. Injury Work	4K INUI		8d. Describe h		Other (Specify	//
Ö	Attending I r death. ector: After by the funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Monat, Day Feat)	Injury	М		es 2□N	10				
Division	I or Atten after deat Director: In by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	Be. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory,	office		2	8f. Location (S City or Tow		Number or Rural	l Route Number,
	pitei ours al		COn Contillor III Continue Physicia	T- Ab- bA - f l l	In dec. ( a A)								
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	edical	(Check only 2 Madical Examinar:	<ul> <li>n: To the best of my knowl On the basis of examination</li> <li>and manner stated.</li> </ul>	n and/or inv	restigation,	it the time in my op	e, date and inion, deati	h occurre	nd due to the c d at the time, d	ause(s) ar late and pl	id manner as sta ace, and due to	ated. the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c.	License	number		2	9d. Date s	signed (Month, L	Day, Year)
	,		* Juhna			D-	<b>-</b> 323.	32			03-0	02-06	
	6		30. Name and address of person who comple			Print)							
	J		Suresh Gupta, M.D.	9801 Georgia	Aven	ue Bui	ildi:	ng 22	0 Si	lver Sp	ring.	MD. 20	0902
	Sta Registr		31. Date filed (Mpm/h-Oak, Year) 2006	32. Registrar's Signatu	A STATE OF	300							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Epruary **Physician** 2006 Dani /Medical 4b. City, Town, or Location of Death 4c. County of Dea 4a. Facility Name (If not institution, et and number) Examiner Bultimore General Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Social Security Number 9. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1936 South Carolina 1 □ M 2 🕱 F Director Usual Residence of Decedent the Maryland 10d. Inside City Limits Department of Health and Mental Hygiene "natural", or Itema 23a or 28a-f show important: If Item 271s marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, Ite Mudical Examinant must be indifficial angines. Since. 10b. County 10c. City, Town or Location 1 Yes 2 No Directo more Naryland

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 mont Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be mes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mant's Name/Relationship (Type, Print) (SON) 21216 101 D.Ma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 200 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Dicenses Approximate Interval Between Onset and Death 23a. Party. Enter the dis shock for heart fail Immediate Cause (Final disease or condition resulting in death) Enter the disease, or complications that caus for heart fail fre. List only one cause on each Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 mor 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 212 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation death. 1 Tes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours of To the Funaral 29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) omplete!v (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature th Day Yea MAR 0 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea **Physician** epru /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death County of Death **Examiner** Home Howa Columb NUISE 201 Jovien If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F June 27, 1928 Maryland 217-24-4670 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Arbutus 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 1253 Maple Avenue 21227 United States Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after oal Hygiena. I Other than "natural", or Iter 1 ☐ Never Married 2 ☑ Married 2 **▼**No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ It Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 homemaker home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fil of Health and Mental H I **item 27 is marka**d otl Be William E. Wimpling Marie E. Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Stromberg - husband 1253 Maple Avenue, Arbutus, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iter
any injury or oth 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State March 2,2006 Sykesville, Maryland 4 □ Donation 5 □ Other (Specify) Lakeview Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. heart gestive Immediate Cause (Final on **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and does detached for usa as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 20 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 Yes 2 No 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA To the Funeral Diractor: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and pitle of certifier 29c. License number MI) oun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowie MD 210 STE CHAULA 14300 Gallen FUX

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2006

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20715

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#28d, Penyll, 8855,5/1/2006, TT

			1 - For State Registrar	'State of M		artment of F rtificate of		Mentai Hy	/giene	06	06452
	(No		Decedent's Name (First, Middle, Last,	)				2. Date of De	eath		3. Time of Death
	Physici /Medi		Edward Jul	lian	Seuter			Februa	rv 22	2006	1018 A M
Jan.	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death			unty of Death	12010
			3300 Church Road			Bowie			Prin	nce Geo	orge's
	Funeral		Social Security Number     6. Security Number		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bid (Month, Da	rth		place (State or Foreign
	Director		052-64-7401	M 2□F	Yrs.	54,0		Nov. 7			
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ecation					0d. Inside City Limits
	Aary!	5									1 ☐ Yes 2X No
	the N	Director	VA Fauquier		Marshall	10f. Zip Code		1	10a Citizaa	of What Cour	
	with Ba or							-		or what Cour	nry r
	ns 23	era	10471 Warland Rd.	12. Was Decedent	Ever in U.S. 13	20115	ispanic Origin? (Sp	ecify Ves or No	USA	Race - Americ	en Indian
36	be tiled within 72 hours after death with the Maryland ital Hygiene. od other then "naturel", or items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ◯ Married	Armed Forces? 1 [X]Yes 2 □ I If Yes, Give	War in	fYes, specify Cuba 1 ☐ Yes 2 🖾 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	etc.
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2	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)		Pres	ident -			Inc.		
anc	uld be fi Mental H irked of	Be	,				18. Mother's Name			name)	
څ	hould d Me mark mark	2	Evert Seuter  19a. Informant's Name/Relationship (Tv	Drive	405 44-70		Dorothy				
Ma	d2s than than 7 ie i		Megan Seuter - Wif				and Number or Run Rd, Mars				Code)
Ġ	1 an Heal Heal	1	20a. Method of Disposition		20b. Place of Dispo	sition (Name of	- 1	Date		on - City or To	State new
Baltimore, Maryland	Pages ment of ant: if it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Little Go Cementer	natory or other place corgetown	2-26			Run, V	
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other trsumatic evonce.		21. Signature of Funeral Service License	rold )			shington S				
			23a. Part1. Enter the disease, or compliantock, or heart failure. List only or	cations that caused	the death. Do not ent	er to mode of dyin	g, such as cardiac	or respiratory a	rrest,	ig, va	Approximate
	Physician		Immediate Cause (Final disease or condition	MI	1 Otra	UIT	nxu	01)			Interval Between Onset and Death
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	ertific ding p	/Me	IF FEMALE:	20 16 100 014 100	111 275						
.O. Box	The law requires that the death cert Ite has been signed by the attendin page 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				Date of delive Month	ny Day Year
<u>.</u>	hat the	F	Part II. Other significent conditions con	tributing to death be	It not resulting in the u	dochina causa ave	on in Bort I	220 Did t	obases use s	aatalbusa sa sh	e cause of death?
Division of Vital Records, P.	en signe	ed by			at not rosulting in the di	identying cadse give	51 III F GIL 1.	1 🗆 `	1 -		ably 4 □Unknown
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<u>~</u>	The ate h page	50							rmed? 2 ☐ No	death?	2□ No
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=	hysi this c	2	ty⊟yYes 2 □ No	ospital: 1 ☐ Inpatie			4   Nulsing Hor	ne 5 ☐ Resid	dence 6XX	Other (Specify	Scene
Ĕ	Attending Physician: or death. ector: After this certifica by the funeral director, t	Certification;	27. Manner of Death  1 □Natural 5 □ Pending	28a. Date of Injur (Month, Da)	Year) Injury	A . 28c. Injury		28d. Describe i		curred	udout in
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<u>&gt;</u>	after Direction by	in a	4 ☐ Homicide determined	building, etc.			+ .	City or Tov	Street and Nur vn, State)	mber or Rural	Route Number, VCl Rd.
	Hospital 24 hours a Funeral I tely filled	2	29a. Certifier 1 ☐ Certifying Phys	icien: To the best of	TELL WWW of my knowledge, death	0,401	the second	BOWLE	MD.	P.G. C	0;
	To the Hospital or Attending Physicien: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only AXMedical Examination)	er: On the basis of and manner sta	examination and/or inv	estigation, in my or	inion, death occurr	ed at the time,	date and plac	e, and due to	the cause(s)
	vithin 2 To the	Σ	29b. Signature and title of partifier	1.	$\mathcal{M}_{\Lambda}$	29c. License	number		29d. Date sig	ned (Month, L	Day, Year)
ŧ	7			40/		OC	ME	F	ebruar	y, 23,	2006
1	201		30. Name and address of person who con	V	ath (Item 23a) (Type, I		nn Street	Ro1+-	more	Mazz-1 -	nd 21201
	Sta		31. Date liled (Month, Day, Year)	32. Registra	r's Signature	1012	ını ətreet	Dall	more,	пагута	nd 21201
	Registr	-	MAR 0 3 2006	A Page Sag o	II Assess						
			1111 11 1 EF LOOU	Charles Alle and	- 4 /						

			For State Registrar		State o	f Marylar			nt of H		and M	ental Hy	giene	06	06453
	1		1. Decedent's Name (First, A	fiddle, Las	st)		·					2. Date of Dea		Von	3. Time of Death
	Physici /Medic		Gerald	Lee	Small <sub>v</sub>	boow						Februar	cy 28	, 2006	12:30 AM
か. 上点	Examin	on it	4a. Facility Name (If not instit	ution, give	street and nur	nber)		4b. City	Town, or	Location of	of Death	-	4c. C	ounty of Death	
		, D	Shady Grove			ospital			ckvil					ntgomer	4
Æ	Funeral Director		5. Social Security Number 168–14–0842		ex M 2□F	7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under Hours	Min	8. Date of Birt (Month, Day Feb. 27	<sup>h</sup> , <sup>Year)</sup> , 192	9. Birth Cor Rid	place (State or Foreign intry) geway, WV
-	pu .		Usual Residence of Deceder 10a, State 10b, Co		<del></del>	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
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36	be tiled within 72 hours after death with the Maryland ital Hygiene. id other then *natural', or iteme 23e or 28e-f ehow event, the Medical Examiner must be notilied at	y Funeral Director	1 ☐ Never Married 2 🔀		Armed Fo	rces?				n, Mexicar Specify:		Rican, etc.)		Black, White pecify:	,etc. hite
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ō,	t Head the the the the		20a. Method of Disposition			20b. F	Place of Dispo	sition (Na	me of	a)		ate	20c. Loca	ation - City or T	own, State
Ē	Pages nent of int: If it iry or o		1 Burial 2 □ Crema 4 □ Donation 5 □ Oth			State	1dwood				3-3-	06	Willi	iamspor	t, PA
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Ser			000	$OO^{\frac{2}{5}}$	Name a	nd Addres Fun Thi	s of Facilit	Home Wi	lliamsp	ort,	PA 177	01
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1	Physician /Medical	1	disease or condition resulting in death)	-		or as a consec		000	7.70	10(1		1.9	<u>, C C</u>	1 0 4)	
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,09/	te be executed ysician and ie burial-transit		resulting in death) Last		Due to (	or as a consec	,	_	-		0		2000		
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n of	ding Physician: The lav h. After this certificete has funeral director, page 2		27. Manner of Death	andina	28a. Date		28b. Time o	1	28c. Injury Work	at		28d. Describe h			
010	endii eath. or: A the fu	catl	2 Accident in	vestigation				М		Yes 2					
Division of	al or Attend s after death al Director: /	Certification:		stermined	286. Place	of Injury - At h ng, etc. <i>(Speci</i>	iome, larm, sti fy)	eet, lacto	ry, office			281. Location (3 City or Tov	Street and i vn, State)	Number or Hu	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending ph completely filled in by the tuneral director, page 2 should be detached for use as it	Medical (	29a. Certifier 1 Cer (Check only 2 Med	tifying Ph lical Exer	ysician: To the niner: On the b and man	best of my kneasis of examination	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	ne, date ar pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
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ì	5'		30. Name and address of pe	rson who		se of death (Ite	m 23a) (Type,	Print)							ND 50811
		-,-	1. CdV,	17	1962	2 P.	) o c p	CNI	DI	1110	(	25,000	ante	100	UD 50811
	Sta Registr		31. Date filed (Month, Day,		6 / 21	legistrar's Sign	ature	de l'							,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06454 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 23 Year 2330 2006 FEB Bettie Catherine Sickle 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HOSPITAL AGNES n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min 1 ☐ M 2 🕱 F Yrs July 29, 1937 216-36-3012 68 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1. Yes 2 □ No Director MD Baltimore <u>Catonsville</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1918 Westchester Ave. 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married Specify: white 1 ☐ Yes 2√2 No Specify: If Yes. Give white 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Control Clerk Social Security 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William H. Eyler Jr. Pansy Arispa Shaw ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Kenneth Sickle - Husband 1918 Westchester Ave. Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

↑☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gardens Feb. 27, 06 Marriottsville 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home anau 3620 Wilkens Ave. Baltimore, MD 21229 23a. Part I. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final dusti on Dehry Unknow disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 100 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 DURKnown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 ER/Outpatient 3 DOA ٩ 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Box o. ۵ ecords. Vital ŏ Division Hospital or Attending

within 24 hours efter death.
To the Funerel Director: A

State

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or than "naturel", or iteme 23e or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be more men of Heelth and Mental Hygiene. tent: if item 27 is marked other than

permit. Page Depertment of Importent: If any injury or

**Physician** 

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page 2 s certificate hes

director,

funeral

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4 - Homicide

(Check only

29a. Certifier

29b

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

29d. Date signed (Month, Day, Year)

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ma) and manner stated 29c. License number Signature and title of certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DO063025 Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMIR CHEEM A

MD

PIKESVILLE RD COURT 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAR 0

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death Day Month 26 A **Physician** 10.37 PM 2006 Harold Clayton Shelton /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Days Hours Min. Yrs. Director 83 1,1923 224-28-2661 Virginia Usuat Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other traumetic event, the Madical Examinativities by notified at Harford Maryland Bel Air 1 Tyes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21015 3134 Nova Scotia Road USA or Items 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after of Hygiene.
I Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pipe Manufacturing Maintenance Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fi of Health and Mental H item 27 Is marked ot George Washington Shelton Cara Mae Vance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lena Shelton - Daughter 3134 Nova Scotia Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Itel
any Injury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 3-4-06 \* 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signatur / Fun va Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final ACUTE MYOCARDIAL INFARCTION Priysician MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. the a 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2/No 1 Yes Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 2 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056607 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 S. ATWOOD RD, #205 RELAIR MD JOSEPH ANGEZO 31. Date filed (Month, Day, Year) 32, Registrar's Signature MAR 0 3 2006 Registrar

MAROLD

			For State Registrar	•	epartment of Health and M Certificate of Death	lental Hygie	ZUUb	06456
			Decedent's Name (First, Middle, Last)	-1 10	1-1-1-1	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Joan W.	Shaffer		march	1 2006	1
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ī	uneral		5, Social Security Number 6. Sex	7. Age (In yrs. last birtho		8. Date of Birth (Month, Day, Yo	9. Birth	place (State or Foreign intry) PERSON N.J.
	Director		214-96 6600	M 2007F 85 Yr	s. Moritis Days Hours Will,	1-23-	1921 Pat	terson N.J.
land	Mo W		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town o	or Location			10d. Inside City Limits
• Магу	a-f sh liffied	ctor	md Freder	ick Was	asboro			1 ∰Yes 2 □ No
it t	or 28	Director	10e. Street and Number	OT	10f. Zip Code	10g	Citizen of What Cou	untry?
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<b>o</b> after d	or Item		1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	, etc.
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TIMOT it. Pages	artment ortant: I injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licenses</li></ul>	West	POINT CEMETRY 3- 22. Name and Address of Fallity - N		n Funera	New York
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Signal Si	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			
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Div A	after I Direct d in by	Certification;	4 ☐ Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, S	State)	
To the Hospital	within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier (Check only 2 Medical Examine	cien: To the best of my knowledge, er: On the basis of examination and/	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the caus	e(s) and manner as and place, and due	stated. to the cause(s)
the H	thin 24 the Formplete	Medi	one)  29b. Signature and title of certifier	and manner stated.	29c. License number		. Date signed (Month	
T	ĭ ¥ 0		> Auks		D26511	. 1	1AR CH	12006
	3		30. Name and aldress of person, who con	npleted cause of death (Item 23a) (T	ype, Print) / A /	NO 16 K	1.0	21717
_			31. Date filed (Month, Day, Year)	32#Registrar's Signature	ANEY TO ME	SEMEN	MU	41114
! -	Sta Registi		MAR 0 3 2006	Trogistial o Orgination	beck			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN TITE 17 Per FH C8/8, 4/1/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day **Physician** 3\_\_ 2006 7:20 AM March Terry Yeager /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk Genesis Eldercare- Heritage If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. March 1,1924 5. Social Security 8906 en 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Pittsburg, PA. 82 219-18-<del>8366</del> Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" ~-" ery hijury or other traumatic even. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐ Yes 2 XNo Dundalk Funeral Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 Apt 314 103 Center Place 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Western Electric Laborer 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alberta E. Cummins Harold R. Cummins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2101 Merritt Avenue, Dundalk, Maryland 21222 Friend Dean Chung 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 6, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, MD. 2006 21. Signature of Fundal Service Licens 22. Name and Address of Facility
Connelly Funeral Home Of Dundlak, P.A. 21222 7110 Sollers Point Road, Dundlak, MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCER Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequer Examiner sicien and burial-transit The law requires that the death certificate be executed HKONIC that initiated events resulting in death) Last Due to (or as a consequence of) EMENT Completed by Physician/Medical the use as attending i 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Øunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has autopsy performed? 2 No To the Hospitei or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 TMo 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation the within 24 hours after deat 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

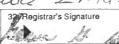
State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Records, P.O. Box 68760.

Division of Vital

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			For State Registrar	State of M	aryland /		rtment of H tificate of I		Mental Hy	giene Reg. No.	006	06458
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State of Maryland / Department of Health and Mental Hygiene [] [] 06660 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :44 DM 22 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltima 7. Age (In yrs. last birthday) Johns Hopkins 1+0 5. Social Security Number tf Under 1 Year 8. Date of Birth (Month, Day, Jan. 12, Birthptece (State or Foreign Country)
 ONLO **Funeral** 1 X M 2 □ F Days 70 280-28-1083 Jan. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, Ite Madical Examinar must be notified at 1 ☐ Yes 2 No Directo VA Prince William Gainesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 13521 Ryton Ridge Lane 20155 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1f Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 1962 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Sales Representative Home Appliances pernit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Denver Quincy Vaughan Amanda Leggett Vaughan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Vaughan (wife) 13521 Ryton Ridge Lane, Gainesville, VA 20155 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) \* 4 Donation 3/1/06 Alexandria, Virginia 22. Name and A dress of Facility
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To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MD 30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) MICHAEL 7. WOLFE STREET BALTMORE, MO. 21287 - 9106 600 NORTH 31. Date filed (Month, Day, Year) 32, Registrar's Signature State 3 MAR Registrar 0

DHMH 17 Rev 1/2001

ORIGINAL

# Florence M. VAN Bibber

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month :40 PM **Physician** /Medical # Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year. Min. Min. Month, Day, Year. 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner WARD 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthdey) 5. Sociel Security Number 6. Sex **Funeral** 1 M 2 F -12-3773 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Department of Health end Mentel Hygiene. Important: If Item 27 ie marked other than "neturel", or items 23e or 25s-f ahow any injury or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2 ☐ No **Funeral Director** 101. Zip Code 10g. Citizen of What Country? 10e. Street end Number 60 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 1No 1 ☐ Yes 2 ☐ No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ANCEA 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN KNOWN 19a. Informant's Name/Relationship (Type, POFELIA LOSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) HOWRD CO OFFICE OF AGING 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee promo 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ata has been signed by the attending physiclen and paga 2 should be datached for use es the bunal-transit or Attending Physician: Tha law requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Debi lily 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24a. Wes en autopsy performed? 101043 1 ☐ Yes 2 10 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificata I completaly filled in by the funeral director, pag 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 20 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Residence 6 Other (Specify) Certification: To 27. Mariner of Death 1 Watural 2 Accident 28c. Injury at Work? 28e. Dete of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 112 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner steted. Medical 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number MI 0006 3681 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) GlenBurnie MD21060 itKuru 115 Roesler 31. Date filed (Month, Day, Year) 32 Registrar's Signeture State MAR 03 Registrar asak.

**ORIGINAL** 

			For State Registrer	State of	Marylar		artment of H		nd Mental	Hygien	000	06462
	Dhysisi	20	1. Decedent's Name (First, Middle,	Last)					2. Date Mon	of Death	ay Year	3. Time of Death
	Physici /Medic		Lucy Theresa	Vito					Feb	. 23,	2006	12:35 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, or	r Location of	Death		c. County of Death	
			Charlestown Ret				Catonsv:		4 Hen   n m		altimore	
	Funeral			i.Sex 7. 1 ☐ M 2 ဩ F		last birthday) Yrs.	Months Days	Hours	Min. (Mon	of Birth th, Day, Year	) Cou	place (State or Foreign intry)
	Director		212-70-1603 Usual Residence of Decedent		96				Dec.	13, 1	909 Sici	1у
	yland Now		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Mar Mar	ģ	MD Baltimo	re	Ca	atonsvi	11e					1 □Yes 2√□No
	h the	ie	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?
	15 will	a	719 Maiden Choi	ce Ln.			21228				USA	
	ams	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U es?	.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Yes Puerto Rican, et	or No-	14. Race - Amer Black, White	
36	72 hours after death with the Maryland natural, or Itams 23a or 28a-f show Jical Exar is at must be motified at	by F.	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2 ☐ No	Specify:	white			white
Ö	hours tural		<del></del>	Year or Date	9S:	160 Dage	dantia Hausi Ossum	ation		105		
7	n 72 • nat	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most o	of working	100.1	Kind of Business/li	ndustry
12	withi ene. than	Ë	Elementary/Secondary (0-12)	Coilege (1-4	or 5+)	Homem		,			Home	
0	e filed within al Hygiene. other than vant, I'e Me		17. Father's Name (First, Middle, La			Homen	aker	18. Mother	's Name (First, A	Aiddle, Maide		
<u>a</u> n	ic ev	To Be	Joseph Colaiann	ıi				Mary	Fontana	zzi		
ary	2 should be to and Mental I is marked or raumatic eva		19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route	Number, City	or Town, State, Zi	p Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic evant, Ita Medical Evar. it at must be retified at once.		Salvatore Vito -	- Son		2705	Bent Tree	e Trai	1, Leag	ue Cit	y, TX 77.	573
ore	of He of He litar		20a. Method of Disposition  ↑□ Burial 2 □ Cremation 3	Domoval from St		Place of Dispo	sition (Name of natory or other plac	(e)	Date	20c. i	_ocation - City or T	own, State
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alt	permit. Departi Import any inj once.		21. Signature of Funeral Service Li	censee			. Name and Addres					Home
ш_	70 E 9 9		MIN XIC	Hang	n		20 Wilker				MD 21229	
			23a. Pann. Enter the disease, or c shock, or heart failure. List or	omplications that cau nly one cause or eac	ised the deat th line.	h. Do not ent	er the mode of dyin	g, such as ca	ardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	_ a	1-	ny	(ance					onsor and Boam
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):						
		<u>-</u>	Sequentially list conditions,	b. — Due to for	as a conse	wence off:						
	ted nsit	nin	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury								1	
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8760,	death certificate be executed e attending physician and id for use as the burial-transit			d								
99	tifical	Physician/Medical								1		
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna h 2 ☐ Feta		Ectopic pregnancy	,			23d. Date of deliv	
E	ie dea the att hed fo	sici	in the past 12 months?  1 Yes 2 No	4□Pregnar 9□Unknow	nt at time of d		Other (specify)				Month	Day Year
P.O.	± > ⊃	Phy	9 ☐ Unknown  Part II. Other significant condition	a contributing to doc	th but not roo	udtina ia tha cu	adashina aayaa ay	on in Part I	230	Did tobacco	use contribute to	the cause of death?
	es ign pe	by	rait ii. Other significant condition	s contributing to dea	ui but iiot 143	alting in the tri	idenying cause giv	en an anti.	200	1 ☐ Yes 2		A en
0	w requir	Completed										
3ec	و ع و	m							<sup>24a</sup>	. Was an autopsy performed?	prior to or death?	opsy findings available empletion of cause of
a	iician: The l certificate ha rector, page		Of the second second second							Yes 💥 N	o 1□Yes	2 No
₹	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☒No	Hospital:	patient 2	ER/Outpatien	Oth		of Death (Check	11	6 ☐Other (Spec	(6.)
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o	Attanding Phy r death. actor: After thi by the funeral o	igi	PQ Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	World M 1 □	k? Yes 2.⊟No	0			
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Ö	tal or A s after at Dira ed in b	Cert	T T T T T T T T T T T T T T T T T T T	Dulluling	, etc. ( <i>Specii</i>	· · · · · · · · · · · · · · · · · · ·			0.1,9	o, , o,,,, o,,		
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	edical		Physician: To the becominer: On the bas	is of examina							
	To the To the To the Comp	Me	29b. Signature and title of certifier	1			29c. Licens	e number	_	29d. D	ate signed (Month	. Day, Year)
			) / ,	1/ W	D		DA	1744	)	Fe	brian	24 2006
1			30. Name and address of person w	no completed cause								40
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	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 3	2006	gistrar's Signa	ature	selle				`	

KEVIN D. WILSON 06-01471 RKD

			Unpend item# 1 - State Registrar	23 State Por Maryland	∯/136β9 Cei	artment of tificate o	Health and I f Death		giene (	16	06463		
	Physici /Medio		1. Decedent's Name (First, Middle, Las KEVIN D. WIL	•				2. Date of Dea Month FEBRUA	Day	Year 2006	3. Time of Death 6:27P.		
	Examir		4a. Facility Name (If not institution, give 5920 FRANKLIN AVE 5. Social Security Number 6. Si		ıst hirthday)	4b. City, Town WOODL If Under 1 Year		1	4c. Count	y of Death	1		
	Funeral Director		246-27-8239 1 Usual Residence of Decedent	XM 2□F 41	Yrs.	Months Day		(Month, Da	y, Year) 5/1965	N.	clace (State or Foreign of try)  CAROLINA		
	the Marylar 28a-f ehow	ector	MD BALTIM		OODL	NWA					10d. Inside City Limits 1 ☐ Yes 21 No		
	th with the 23a or 2 ust be no	al Dire	10e. Street and Number 5920 FRANKLIN	AVENUE, 2B		10f. Zip Code	21207		10g. Citizen of USA	What Cou	ntry?		
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "netural", or Iteme 23s or 28s-1 show other traumette event, the Medical Examinational be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puert Suban, Mexican, Puert Suban, Mexify:	pecify Yes or No- o Rican, etc.)		ice - Americack, White, ify: $\mathrm{BL} R$	etc.		
21215-0	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other then "netural; or iteme eumetic event, II a Medical Examinatina	completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2 T H	cation fe completed) College (1-4or 5+)	(Give life. l	lent's Usual Occ kind of work doi OO NOT use ret [NTENA]	ne during most of wor ired)	king	16b. Kind of I MONDA! MALL		dustry RETAIL		
Maryland	ould be filed wental Hygis arked other atic event, to	To Be C	17. Father's Name (First, Middle, Last) CLIFTON BROO	KS				ne <i>(First, Middl</i> e, E BARNE		me)			
	nd 2 sho alth and 27 is mu r troum		19a. Informant's Name/Relationship (7 ELLIE BROOKS /	ype, Print) MOTHER			et and Number or Ru ARDSON RI				•		
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify	Leurovar irom prare  DBII	ace of Dispo metery, cren ID R	sition (Name of natory or other p DGE CI	EM. 03/	Date / 04/06	20c. Location		own, State		
Balt	permit. Departr imports eny inje		21. Signature of Funeral Service Licen	8. Naute			dress of Facility HO				ME 21207 TIMORE, MI		
	rate be executed // Medical Examiner and its print transit tra	Examiner	23a. Fign. First the disease, or companies, heart fallure. List only immediate ause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. End of the cause of the cau	rest,		Approximate Interval Between Onset and Death							
.O. Box 68760,	n certific inding p use as	Physician/Medica	d										
rds, P.	w requires that the death been signed by the atte should be detached for		Part II. Other significant conditions of	ntributing to death but not resu	Iting in the u	nderlying cause	given in Part I.				he cause of death?		
of Vital Records,	The law receled has bee page 2 sho	Completed by								prior to co death?	opsy findings available impletion of cause of		
f Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ∑Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ 8	ER/Outpatier	t 3 DOA	7th as	ath <i>(Check only o</i> lome 5☐ Resid		her (Specil	v) SCENE		
Division o	To the Hospital or Attending Physician: The law within 24 hours after death.  Yo the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	٧		28d. Describe h	now injury occu	irred			
Divi	tai or Att rs after d al Direct ed in by I	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str )	eet, factory, offic	ce .	28f. Location (S City or Tou		ber or Run	al Route Number,		
	To the Hospital or within 24 hours afte No the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Post of the P	Medicai		/sician: To the best of my know iner: On the basis of examinati and manner stated.									
	To the comp	M	29b. Signature and title of certifier	00 10			ense number		29d. Date sign	,			
1	)		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	.C.M.E. n Street l		FEBRUAR				
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 0 3 2006	2. Registrar's Sigoat	ure	iii ren	n priest 1	Darchiol	e, rary	Tanu	<u> </u>		

Gabriel Willis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#1 perstate of Waryland Department of Health and Mental Hygiene

Amend item#1,23a,27,perFH, Fertificate of Death

Registrar 06-01197 MIM1 - For Stata Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death GABRIEL WILLIS <sup>Day</sup> 16 February **Physician** 2006 Willis gabriel 0843 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A Baltimore
Under 1 Year | If Under 24 Hrs. <u>Sinai Hospital</u> If Under 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 M **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 XM 2 ☐ F Yrs Director 24 N/A Jan 23,2006 Baltimore Usual Residence of Decedent Maryland 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at N/A Baltimore Maryland Mar Yes 2 No Director the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with ō 21223 USA 1811 Pulaski Street itams 23a death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify:Black 3 ☐ Widowed 4 ☐ Divorced nature 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) other t 0 permit. Peges 1 and 2 should be filed.
Department of Heelth and Mental Hygu Important: if Item 27 is merked other eny injury or other traumout. traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sandra Willis John Smith ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 Pulaski Street Baltimore, Maryland 21223 Sandra Willis/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State Zion Cemetery 2/20/06 Lansdowne, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman - Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Usensee Non 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Bronchopneumonia associated with bactermia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed use as tha burial-transit nding physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ¥es 2□ No this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. neral Director: A filled in by the fo 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check unity one) P. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) min OCME February, 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING I mio 111 Penn Street Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 3 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygies

iD.	I. MIT	טט	1 - For State Registrar	State of Maryla	-		te of De		vientai Hy	Reg. No		06466
ŀ	Physici	ian	1. Decedent's Name (First, Middle, Las	JAMES P	. WEISS				2. Date of De			3. Time of Death
ŧ	/Medi	cal	An Carille Name (16 and institution -	-111		45.00	<b>T</b>		FEB.	25,	2006	1926 P M
}	Examir	ner	4a. Fecility Name (If not institution, give ROUTE # 4 @ THOMAS	JOHNSON BRI	TYCE		TOWN, OF LOC	ation of Deatr			c. County of Deat CALVERT	n
	Funeral Director		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday 72 Yrs.			Under 24 Hrs. ours Min.	8. Date of Bi (Month, Da June	th v. Year	9. Birt	hplace (State or Foreign buntry) irginia
	/land		10a. State 10b. County	10c.	City, Town or L	ocation						10d. Inside City Limits
	a-f eh	ctor	Maryland Calver	t			Lusl	ру				1 ☐ Yes 2 No
	23e or 28	rai Director	10e. Street and Number 50 Ap	peal Lane		10f. Z	ip Code	20657		10g. Ci	g. Citizen of What Country? USA	
2-0030	be tiled within 72 hours after deeth with the Maryland ital Hygiene. od other then "naturel", or Iteme 23e or 28e-1 ehow event, the Medical Examiner mant by notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 U.S. 13.		edent of Hispar ecify Cuban, M 2X No Si		pecify Yes or No Rican, etc.)	)-	14. Race - American Indian, Black, White, etc.  Specify: White	
<u>۾</u>	72 ho	etec	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a. Dece	edent's Us e kind of w	ual Occupation ork done durin use retired)	g most of wor	king	16b. K	(ind of Business/	Industry
7	within 72 ene. then "na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired) C Work			Ci	ty of G	reenbelt, Md
0	Hygin other	Be Co	17. Father's Name (First, Middle, Last)						ne (First, Middle	, Maider	n Sumame)	
yland	should be and Mental marked of umatic eve	To B		William We	eiss			Agn	es (Un	know	n)	
Mar	01 00 = 00		19a. Informant's Name/Relationship (T								or Town, State, 2	Zip Code)
e o	1 and Health em 27 ther to		Lesia Nelson  20a. Method of Disposition	(Daughter	Acres and the second se			nue, Ba	ltimore		aryland	21227
DE L	8 2 = 5		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		o. Place of Disp cometery, cre ates of			3/	3/06			ng, Maryland
Baltimo	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licens									225–1856
			23a. Part1. Enter the disease, or comp	lications that caused the de	eath. Do not er	of the mo	ratap de of dying, su	sco Ave	or respiratory a	rrest,	Md. ZI	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. MVITIPLE  Due to (or as a cons	equence of):	VRII	22					Interval Between Onset and Death
	be sit	liner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	saquenou of)r							
	xecut	Examin	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):							
09/80	tificate be executed ig physicien and as the burial-transit			d								
T.	rtificat ng phy as th	Medical	IC CEMALE:									
C. BOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fi 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic p □ Other (s					23d. Date of deli Month	very Day Year
cords, r	quires thet	þ	Part II. Other significant conditions co	ntributing to death but not r	resulting in the t	underlying	cause given in	Part I.		obacco (	¥ .	the cause of death?
T T	The law re ite has bet oage 2 sho	Completed							24a. Was auto perfo	osy irmed?	prior to death?	topsy findings available completion of cause of
VII	sian: artifice ictor, p	Bec	25. Was case referred to medical examiner?			175-20-0			th (Check only o	ne)		
5	Physic this c	ပ	TYTY es 2□ No		ER/Outpatie		OA Other: 4	☐ Nursing H	ome 5 Resi	dence	6 X Other (Spec	erry) AT SCENE
DIVISION	ending feath. or: After he funer	cation	27. Manner of Death 1 □ Natural 5 □ Pending 2 SAccident investigation	28a. Date of Injury (Month, Day Year) 2/25/06	28b. Time of Injury 6:56	Рм	28c. Injury at Work? 1 ☐ Yes	2 <b>2</b> No		of co	AR IN C	DUISI OU
	s after d	Certification:	3 ☐ Suicide 4 ☐ Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  RAD							Street an vm, State DIAS	Number or Ru	ral Route Number (n f)  Sr. ALVERT CO
	he Hospi n 24 hour ne Funer	edical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deal	th occurred nvestigation	at the time, do	ate and place, n, death occur	and due to the red at the time,	cause(s)	and manner as d place, and due	stated. to the cause(s)
	Withii withii comp	Me	29b. Signature and title of certifier  O.C.M.E							29d. Date signed (Month, Day, Year)		
ļ	n_<		P Ullat 2				U.C.M	. L		FE	D. 20,	2006
1	)		30. Name and address of person who c		tem 23a) (Type) $11~{ m PENN}$		EET, BA	LTIMORI	E,MARYL	AND 2	21201	
ı	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Asse			-			

			State of Maryland / Department  1- State Registrar  Certificate			2111h	16467
			Registrar  1. Decedent's Name (First, Middle, Last)	or Death	2. Date of Death	g. No.	3. Time of Death
	Physici	an	Gertrude Houser Ward		Month	Day Year	
	/Medic Examin			own, or Location of Death	February	y 27, 2006 4c. County of Death	9:00 P M
	Examin	eı		erdeen		Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		8. Date of Birth (Month, Day,		place (State or Foreign ntry)
	Director		281 <b>-</b> 10-3780	Days Flours Will.	Feb. 9,	1912 Ohio	
	pu s		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	f sho	5	Maryland Harford Aberdeen				1 ☐ Yes 2 ☑ No
	the t	rect	10e. Street and Number 10f. Zip C	Code	10	g. Citizen of What Cou	intry?
	3a or	Funeral Director	650 Burkley Avenue	21001		USA	
	deati	ner		ent of Hispanic Origin? (Spe fy Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White	
ထ္ထ	or Ite	교	1 Never Married 2 Married 1 Yes X No		110411, 010.,	Specify:	, 610.
8	ural',	d by	Widowed 4 □ Divorced Year or Dates:			TV	hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-f show ite Modical Exciting to mat be codified a	Completed	life, DO NOT use	done during most of workii	ng 1	6b. Kind of Business/Ir	ndustry
72	iene.	E	Elementary/Secondary (0-12) College (1-4or 5+)  12 Teacher			Artist	
ष्ट्र	oths rent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		
/lar	uid b Wenta Irked	To E	Oscar David Kaufman	Beulah In	ndepender.	nce Houser	
Maryland	2 sho and l		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing Address (	(Street and Number or Rura	I Route Number,	City or Town, State, Zi	p Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or Itema 23a or 28a-f show any injury or other traumetic event, it is Modest Examitter and be notified at 2008.		Patricia Ward/ Daughter 650 Burkle	y Ave. Aber		ryland 210	
Baltimore,	iges 1 If of H or of		1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State cemetery, crematory or oth	her place)		0c. Location - City or T	own, State
Ξ	it. Pa rtmer rtent njury		'4 □ Donation 5 □ Other (Specify) Hillton Servic  21. Signature / Funeral Service Licenses / 22. Name and	re Corp. 3-1-	·06 I	lowson, Mar	yland
Ba	permi Depa Impo any ir		McComas	Address of Facility S Funeral Hom	e, P.A.		3 01 000
	_		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode	okesbury Road of dying, such as cardiac o	r respiratory arres	ion, Maryla st,	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Mond			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a	or year			
	Examiner		Sequentially list conditions, b. Mpmmons on				
-	.b/ =	iner	cause. Enter Underlying				
0	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			-	
8760,	ate be executed the burial-transit	cai E					
687	ficate p physical phy		0.				
Вох	law requires that the death certific: as been signed by the attending pl 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1	on an ev		23d. Date of deliv	,
B	deat	sicia	in the past 12 months?  1 \( \text{Yes} \) 2 \( \text{No} \)  4 \( \text{Pregnant at time of death} \)  5 \( \text{Other (special)} \)			Month	Day Year
P.O.	res that the de signed by the a be deteched f	Phy	9 U ONKNOWN		OZ- Didash		the course of death?
	res th	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part i.		acco use contribute to acco use contribute to acco use contribute to acco use contribute to acco use contribute to acco use contribute to acco use contribute to acco use contribute to acco use contribute to acco use contribute to acco use contribute to acco use acco use acco use acco use acco use acco use acco acco use acco ac ac ac acco ac ac ac ac ac ac ac ac ac ac	_/
Ö	w require been si	etec			-		
Records,	The law ate has I bage 2 s	Completed			24a. Was an autopsy perform	prior to co	opsy findings available empletion of cause of
Vital	in: Th	e Co	25. Was case referred to medical	26. Place of Death		1 Yes	2 No
>	Physician: this certific ral director,	ToB	examine/? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA	Othor	./	nce 6 Other (Speci	(fy)
υot	ng Ph ter th		27. Many r of Death 1 vatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury		28d. Describe hov		7
30	Attending r death. sctor: After by the fune	atic	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
Division	or Att	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at	It the time, date and place	and due to the cou	use(s) and manner as	hateta
	the Hospitei hin 24 hours a the Funeral I npletely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, i and manner stated.	in my opinion, death occurre	ed at the time, dat	te and place, and due	to the cause(s)
	To the Hospitel within 24 hours a To the Funeral Completely filled	Me	29b. Signature and title of certifier 29c.	License number	296	d. Date signed Month,	Day, Year)
)			Hi Sup Sim	174641		4/28/06	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	[1]	04. 2	C	
100	Ψ		31. Date lied Mont, Day, Year) 2. Registrar's Signature	ring inn	0/01	3	
Ny.	Sta Registi		MAR 0 3 2005				
			Million O C COOL WINGS				

			1 - For State Registrar	State of Ma	aryland		artmen tificate			and M		giene	IIIIh	06468	
age.	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of De. Month	ath Day	/ Year	3. Time of Death	
	/Medic		LORIS						SERMA		MARCH	1	L 2006 9:55 A		
	Examin	er	4a. Facility Name (If not institution, give st COPPER RIDGE NURSI					SVIL	Location o	of Death		4c. County of Death			
	Funeral		5. Social Security Number 6. Sex		(In yrs. la:	st birthday)	If Under	1 Year	If Under		8. Date of Birt	CARROLL  9. Birthplace (State or Foreign			
316	Director			M 27 F	90	Yrs.	Months	Days	Hours	Min.	12/14/1	1915		CT CT	
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Limits	
	Maryl feho	tor	MD CARROLL		SY	KESVII	LE						1 ☐ Yes 2X No		
	h the	Funeral Director	10e. Street and Number				10f. Zip	Code		-		10g. Cit	zen of What (	Country?	
	23a c	ralD	710 OBRECHT ROAD				2	1784					U.S.A.		
	er des	une		<ol><li>Was Decedent E Armed Forces?</li></ol>		<ol> <li>J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>							<ol> <li>Race - An Black, Wh</li> </ol>	nerican Indian, lite, etc.	
39	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or fleme 23a or 28a-f ehow int, the Medical Examinar must be motified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	10		∏ Yes 2	2 <b>X</b> ) No	Specify:				WHITE		
21215-0036	72 hor	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occupation (Give kind of work done during m					t of work	ina	16b. Ki	nd of Busines	s/Industry	
2	hen "	mple	Elementary/Secondary (0-12)	Coilege (1-4or 5	+)	life. I	DO NOT us	O NOT use retired) MEMAKER					OVIN HOME		
р Б	filed v Hygie ither t		17. Father's Name (First, Middle, Last)			П	JNENA	NEK	18. Mothe	or's Name	e (First, Middle,	Maiden	OWN F	TOME	
au	id be ental ked o	To Be	MORRIS		CAI	LEGMAN	V			PEAR			,	COHEN	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Me	-	19a. Informant's Name/Relationship (Typ	e, Print)	J.			(Street a			I Route Numbe	er, City o	r Town, State,		
Σ	and 2 ealth a m 27 is		MARTIN WASSERMAN /	SON	- [				PHIA					MD 21042	
lore	Pages 1 and 2 nent of Health ant: If Item 27 ary or other tra		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cen	netery, cren	natory or of	ther place			Date		cation - City o		
Baltimore,	그는 변경 .		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	9	EMAI	NUEL S			the same of the same of the same of	Who is hoped to be in the second	3/2006 h	-			
Ba	permi Depa Impo any ii		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS 8900 REISTERSTOWN ROAD - PIKESVILLE											•	
W			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lin	the death.								OVILLE.	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Pn-	enm	00								Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	a conseque	ence of):									
189		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseque	ence of):									
	cuted nd ransit	Examiner	that initiated events												
8760,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a	a conseque	ence of):									
387	physicate to physical	dlca	d.												
Box 6	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome									23d. Date of d	elivery	
œ.	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pre Other (spe						Month	Day Year	
<u>Ч</u>	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions cont	abuting to dooth bu		ing is the	alaskijas sa		a la Dani I		220 Did to			to the serve of death?	
ds,	signe d be c	d by	Coron-y Demantis	Prfy	D.	الا المانية المانية المانية المانية المانية المانية المانية المانية المانية المانية المانية المانية المانية ال	tuerrying ca	ause give	n in Pan I.			res 2		to the cause of death?	
CO	w requ	lete	Demention						•		24a. Was	an	24b. Were a	autopsy findings available	
Re	The lay te has age 2	Completed						-			autop perfo	rmed?	prior to death?	completion of cause of	
ita	ian: rtifica stor, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death	1 Yes	2 No	IL TE	S ZUNU	
× >	hysic his ce	P	1 ☐ Yes 2 ☑ No Ho			R/Outpatien			4 ESTINUI	rsing Ho	me 5 🗆 Resid	dence (	3 □Other (Sp	ecify)	
SPOOD BY THE TOTAL PART OF THE TOTAL PART OF THE TOTAL PART OF THE TOTAL PART OF TOTAL									now injur	y occurred					
isi	death death ctor: y the	flcat	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ırv - At hom	ne, tarm, stre	M eet, factory		es Z		28f. Location (S	Street an	d Number or F	Rural Route Number.	
2	al or A s after il Direct	Certification:	4 Homicide	building, etc	. (Specify)						City or Tox			,	
	To the Hospital or Attending Physician: The I wilhin 24 hours after death.  To the Funeral Director: Attenthis certificate he completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	er: On the basis of	examinatio	ledge, death on and/or inv	occurred a	at the tim in my op	e, date and inion, deat	d place, a	and due to the o	cause(s) date and	and manner a	is stated. le to the cause(s)	
	o the	Med	one) 29b. Signature and title of certifier	and manner sta	ted.		29c.	License	number	-		29d. Dat	e signed (Mor	nth, Day, Year)	
)	- 3 - ō		> Run I. W	in ine	9		6	172	ا حود	7		3/	1/0	6	
	12		30. Name and address of person who con	npleted cause of de	eath (Item 2	23a) (Type, I	Print)	1	N		0	1	6	me 21136	
48	,		Robert L. Mo	32. Registra	B-1		C	- 4 -	Ja.		たいナンプ			21136	
	Sta Registr	-	MAR 0 3 201	06 Jesus	Ran Say	I A	West of								

			1 - For State Registrar	State of Ma	-	epartmen Certificate					gien,	7111	6	0646	9
	Physic /Medi		Decedent's Name (First, Middle, Last)     William Harold							2. Date of De Month March	2 Da	<sup>ay</sup> 2006	Year )	3. Time of De 8:25a	ath M
1	Examii		4a. Facility Name (If not institution, give s Gilchrist Hospic	e			Tows						timo	ore	
	Funeral Director		United Bridges of Breeden	7. Ag	e (In yrs. last birt	hday) If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Aug 4	192	7	9. Birthi	place (State or F ntry)	oreign
	Maryland e-f ehow	ctor	10a. State Md Carroll		10c. City, Town Fi	or Location nksburg					-			10d. Inside City I	
	th with the 23s or 28	al Dire	10e. Street and Number 1887 Lakeland Dr	rive		10f. Zip 21	Code LO48				10g. C	itizen of W USA	hat Cou	ntry?	
920	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f ehow he Mudical Examinat must be positived at	by Funer	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ∰ Yes 2 ☐ I If ¥es, Give Year or Dates:		13. Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	)- 	Black	- Ameri k, White, Whi		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other treumatic event, "he Medical Examinet must be usufficed at once.	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5 4		Decedent's Usua (Give kind of wor life. DO NOT us plastic	rk done d se retired	luring mos: )		ng		Kind of Bu		ŕ	
Maryland	ould be file Mental Hy arked oth atic event	To Be (	17. Father's Name (First, Middle, Last) William Harold							(First, Middle Kinyon	, Maidei	n Sumame	9)		
	and 2 sho eelth and m 27 is m		19a. Informant's Name/Relationship (Ty) Jolene C. Young (sp		18	Mailing Address 87 Lake1	land	Dr.,	Fin!	ksburg,	Md	2104	.8		
Baltimore,	. Pages 1 tment of H tant: If ite jury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemeter	Disposition (Name), crematory or of ounty Cre	ther place emati	lon :	3-3-0		Syk	esvil	1e,		
Bal	permit Depar impor any in		21. Signature of Funeral Service License  Page Haught H	enbert		P.O. E	30.2	1	95 S	ght Fur ykesvil	le,				
·	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		a consequence of	der		g, such as			rrest,			Approximate Interval Between Onset and Dea	ith
1%	Examiner post	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	f):									
,0928	cate be executed physicien and the burial-transit	cal	resulting in death) Last	Due to (or as	a consequence o	f):					-				
P.O. Box 6	res that the death certifics igned by the attending pl be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ⊟Ectopic pri 5 ⊟ Other (spe						23d. Date Mon		ery Day Yea	r
	quires that n signed b uld be deta	<u>م</u>	Part II. Other significant conditions con	tributing to death b	ut not resulting in	the underlying ca	ause give	on in Part I.		23e. Did t				he cause of deat	
al Records,	ician: The law requir certificate has been si ector, page 2 should I	Completed								24a. Was auto perfo 1 Yes		pi di	ere auto for to co eath?	ppsy findings ava mpletion of caus 2 No	ilable e of
ion of Vital	ding Phys	tlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Dat			8c. Injury Work	<sup>0□</sup> 4 🗆 Nu	rsing Hon	_(Check only only one 5 □ Resident Res	dence			n Hosp	ice
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, far c. (Specify)	m, street, factory	, office		2	28f. Location ( City or To	Street ai wn, State	nd Numbe e)	r or Aura	al Route Number	
	To the Hospitei or within 24 hours effet To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of ter: On the basis of and manner sta	examination and	death occurred a for investigation,	at the tim in my op	e, date an	d place, a th occurre	and due to the ed at the time,	cause(s date an	and man d place, a	ner as s	tated. o the cause(s)	
	To T	Σ	29b. Signature and title of certifier	mlle	ly , a		License		5		29d. Da	ate signed	(Month,	Day, Year)	
	P		30. Name and address of person who co	GBINC	a (Item 23a) (	Type, Print)	hor	les S	t.	Bali	to	md	Z	120%	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	And -									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death y 27, Žero6 Month Day Clarence Edward Zerhusen 10:57FM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Apr. 7, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign 1**√** M 2□ F Mary Tand 215-28-2422 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Timonium Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 5 Bertwell Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No IX es, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 🛣 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 State of Maryland Employment Coordinator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Naomi Hall Henry A. Zerhusen, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Bertwell Court: Timonium, MD 21093 wife Elaine F. Zerhusen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation Other (Specify) Timonium, MD Dulaney Valley Mem Gardens 3/3/06 1050 York Road 21. Signature of Juneral Service Lidense 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cays on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASYSTOLE Due to (or as a consequence of): MYOCARDIAL INFARCTION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DENGESTIVE HEART FAILURE Due to (or as a consequence of):

**Physician** /Medical Examiner Examine The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

2

**Funeral** 

Director

r than "natural", or Itams 23a or 28a-f show the Medical Examinar most be notified at

within 72 hours after death

al Hygiene.

nd 2 should be filed lith and Mental Hygid 27 is marked other r traumatic avent, iii

permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is any Injury or other trau

Baltimore, Maryland 21215-0036

led by the attending physicien and detached for use as the burial-transit Physician/Medical ð After this certificate has been s funeral director, page 2 should Be Completed Medical Certification: To To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A filled in by the

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions (	contributing to death but not re	sulting in the underlying	g cause given in Part I.		use contribute to the cause of death?
				24a. Was an autopsy performed? 1 ☐ Yes 2 D No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□	Other	ath (Check only one)  Home 5 ☐ Residence	6 ∏Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injur	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, fact fy)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best of my kn miner: On the basis of examin- and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. I place, and due to the cause(s)

29c. License number

D 52749

OSLER DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year) 03

06

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

September 1

HIRPARA

2006

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7621

			1 - For State Registrar	State of N	Marylan	d / Depa <i>Cei</i>	artment rtificate	of H	ealth ai <i>Death</i>	nd Me		iene	3	06471
	\$3 at		1. Decedent's Name (First, Middle, La	ast)						2	Date of Deat	h Day	Year	3. Time of Death
	Physici /Medio	_	Gian Anand							F	ebruary		Teal	10:35 a <sup>M</sup>
	Examir		4a. Facility Name (If not institution, gi	ve street and numbe	ər)		4b. City,	Town, or	Location of	Death		4c. County	of Death	
			Fairland Nursing Hom	e					pring			Montgor	nery	
£	Funeral Director		274-88-1865	Sex 7. 1 □ M 2 □ X F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	Date of Birth (Month, Day, larch 3,	<i>Үөаг)</i> 1940	9. Birth Cou Pakis	place (State or Foreign intry) tan
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City	. Town or Lo	cation							10d. Inside City Limits
	Maryl 1 sho	ō	Maryland Montgom	erv	Silve	er Sprin	ng							1 ∑ Yes 2 ☐ No
	28a	Director	10e. Street and Number			•	10f. Zip	Code			11	Og. Citizen of V	/hat Cou	intry?
	3a o	D	2101 Fairland Road				209	04			Un	ited Sta	ce Am	erica
	deat	Funeral	11. Marital Status	12. Was Decede Armed Force			Was Deced	ent of His	spanic Origi	in? (Speci	fy Yes or No-		- Amer k, White	ican Indian,
36	72 hours after death with the Maryland natural', or tems 23s or 28s-1 show disal Examinat must be rudified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2[ If Yes, Give Year or Date	X No		1 ☐ Yes 2	_	Specify:	1 0010 111	outi, 610.)	Specify		ian
9	2 ho	ted	15. Decedent's E				dent's Usua kind of wor			of working		16b. Kind of Bu	siness/li	ndustry
121	within ene. than "	Completed	(Specify only highest games (Specify only highest games) Elementary/Secondary (0-12) 12	College (1-4c	or 5+)	`life. I	ome Mak	e retired)	uring most	or working		Owned H	ome	
and 2	al Hyg	Be	17. Father's Name (First, Middle, Las	t)					18. Mother		First, Middle, N	faiden Sumam	9)	
Ž	should be ind Menta i marked umatic ev	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	na Address	(Street a			Route Number.	City or Town,	State. Zi	p Code)
N S	nd 2 s lith ar 27 ls r trau		Amardeep Anand/Son								le, Virg	•		
Baltimore, Maryland 21215-0036	Pages 1 and 2 should bent of Health and Ment nt: If tem 27 is marked by or other traumatice		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spec		te Ce	lace of Dispo emetery, crer imore Wa	natory or ot	her place		Dai bruary y	28, 200	20c. Location - 6 Laurel, i		
Balti	permit. Pages I Department of H Important: If Ite eny injury or ot		21. Signature of Funeral Service Lice	2 Patr	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		2. Name and				eck Funer	al Home	20707	
1			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nelications that cause on each	sed the death									Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition		le Scle	rosis								Onset and Death 2 years
Ser	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):						-		
	Lxammer	_	Sequentially list conditions,	b. Due to /or	as a consequ	rence of):								
	ted nsit	n in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	10) 01 900	as a consequ	Jence on.								
	te be executed ysician and e burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):							_	
8760,	siciar siciar s burii	dical E	(	- d										
9	ificate g phys as the	edi		V										
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pre Other (spe					23d. Dat Mor		very Day Year
۵.	uires that signed by Id be deta	þ	Part II. Other significant conditions	contributing to deat	n but not resu	alting in the u	nderlying ca	iuse give	n in Part I.		23e. Did tob	_		the cause of death?
S	w requ been shoul	ete									24a. Was ar	24b. V	Vere aut	opsy findings available
Vital Records,	The lay	Completed								-	autops perform	ned?	rior to co	ompletion of cause of
ta		0	25. Was case referred to medical						26 Place o	of Death (	1 ☐ Yes 2 Check only one	Λ	195	2 No
<u> </u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 🗆	ER/Outpatier	nt 3□ DO.	A Othe	r.			nce 6 □Othe	er (Spec	ífy)
on of	ng fee		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of I (Month,	njury Da <i>y Year)</i>	28b. Time of Injury	f 28	3c. Injury Work 1	at ? es 2 □ N		d. Describe ho	w injury occurr	ed	
Division	i Dite	Certification:	3 Suicide 6 Could not 4 Homicide determined	286. Place of	Injury - At ho etc. (Specify	ome, farm, str	eet, factory	, office		28	f. Location (Sti City or Town	reet and Number, State)	er or Rui	al Route Number,
	Hospi 4 hour uner	Medical (	29a. Certifier (Check only one)  1  Certifying P 2  Medical Exa	hysician: To the bearing. On the basis	s of examinat	wledge, death tion and/or in	h occurred a vestigation,	at the tim- in my op	e, date and inion, death	place, an occurred	d due to the call at the time, da	use(s) and ma ate and place, a	nner as ind due	stated. to the cause(s)
	To the within 2. To the F	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date signed	(Month	, Day, Year)
	. , 0		John .				D2	28656			N	March 2,	2006	
<b>*</b>			30. Name and address of person who Ravi Passi, MD 8609	Second Aven				Spri	ng, Ma	ryland	20910			
	Sta		31. Date filed (Month, Day, Year)	100	strar's Signa	ture	» di			-				
14	Regist	ar	MAR 0 6 20	U6 15000		4.000	B. B.							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Betty Loiuse Auston March 2006 **Physician** 4:56A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Ritchie Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8-1-59 5. Social Security Number 245-54-0742 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) NC 1 M XXF 46 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hyglene. Important: if item 27 is marked other then "naturel", or items 23a or 28e-f ehoven hy Injury or other treumatic event, the Madical Examinar must be notified at once. MD Baltimore XXes 2□No Completed by Funeral Director 1014 N. Fulton Ave. 10f. Zip Code 10g. Citizen of What Country? 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X X 0 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thurman Auston Elvina Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elvina Auston 1014 N. Fulton Ave. Balto.MD 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Trinity Cemetery 3-9-06 Dundalk, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licenses 22. Name and Address of Facility Wesley Chavis, Jr FH SH 2007 Eastern Ave. Balto.MD 21231 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) MOLTH **Physician** METASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit end Due to (or as a consequence of): Box 68760, the ettending physicien Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Š cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 NUnknown peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physicien: The law within 24 bours after death.
To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2. autopsy performa 2 🗆 No 1 Yes 1 Yes Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSP) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29a. Certifier Medical 29b. Signature and title of gertifie 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Hern 2pa) (Type, Print) 30. Name and address of person Cato ZDVM Date filed (Month, Day, Year) Registrar's Signature State Registrar 2006 6

lobert R. Bergman Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 6-1460 State of Maryland / Department of Health and Mental Hygiene KG 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 27, **Physician** Robert 2:12 Рм Dergman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6110 Shipview Way Baltimore n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**5**M 2□F 216-42-6513 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 0d. Inside City Limits Worle 27 is marked other than "netural", or items 23a or 28a-f show traumatic event, the Mudical Extrainer must be notified at 1 Yes 2 □ No Director Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6110 21224 U.S.A. Was Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Slatus 1 Never Married 2 Married 1 ☐ Yes 2 M No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Şecondary (0-12) College (1-4or 5+) aborer andsca 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be Bergman lensor Duris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 2705 Konald 21207 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its eny injury or ot once. other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory of 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee Nou 170/Mela 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a GASTROINTESTINAL HEH ORKHAGE /Medical Due to (or as a consequence of): Examiner PUPTURED BSOVHAGEAL VARYX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit CIRRHOSIS Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown s been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ DISEASE, PULTIONARY 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of VENRICULAR Director: After this certificate has I in by the funeral director, page 2 autopsy performed? death? 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) At Scene Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To MXYes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 28, 2006

State Registrar 31. Date filed (Month, Day, Year) MAR 0 6

ANA

32 Pegistrar's Signature

HD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Joseph

111 Penn Street, Baltimore, Maryland

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of Hea rtificate of De	alth and Me eath		ne2 0 0 6	06474
Ε	Physici	an	Decedent's Name (First, Middle, Last)					Date of Death     Month February 28	Day Year	3. Time of Death
	/Media	al	Kenneth Eugene Boles			4h City Town and a		rebruary 20	4c. County of Deat	8:50 p M
1	Examin	er	4a. Facility Name (If not institution, give : Holy Cross Hospital	street and number)		4b. City, Town, or Loc Silver Spr			Montgomer	
	Cuneval		Social Security Number 6. S	7. Age	(In yrs. last birthday)	·	Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign untry)
П	Funeral Director		306-22-2086	M 2□F 77	Yrs.	Months Days H	lours Min.	(Month, Day, Y May 7, 1928	8 India	na
	P		Usuel Residence of Decedent	-	40.00.					
	arylar show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f	Director	Maryland Prince Geo	rge's	Laurel	100 70 00 10		10-	. Citizen of What Co	
	with t		10e. Street and Number 8900 Boxford Court			10f. Zip Code 20708			ited State A	•
	he 23	era	11. Marital Status	12. Was Decedent 8	Ever in U.S. 13.	Was Decedent of Hispar	nic Origin? (Spe		14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23e or 28e-f show amy injury or other traumatic event, the Medical Examinar mast be notified at ODGe.	by Funerai	1 □ Never Married 2 ☑ Married . 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	1944	Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes 2 No Si	dexican, Puèrto F pecify:	Rican, etc.)	Black, White	
Maryland 21215-0036	2 hou	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occupation	)	16	b. Kind of Business/	ndustry
2	Bn "n Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+) (Give	kind of work done durin DO NOT use retired)	ig most or workin	ng		
2	ed wil	Con	12		Fil	m Producer			Private	
nd	d oth	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Ma	iden Sumame)	
<u>ya</u>	ould Men Parke natic	2	Eugene Boles	- / .			Cecile Wri			
Mar	12 sh h and 7 is m fraum		19a. Informant's Name/Relationship (Ty Gay Boles/wife	pe, Print)		ng Address <i>(Street and :</i> Boxford Court			city or Town, State, 2 0708	ip Code)
ص ب	1 and Healt em 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			c. Location - City or	Town, State
Baltimore,	ages int of t: If It y or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	National (	matory`or other place) Prematory	  March 5		ls Church, \	
	artme ortan injury		21. Signature of Funeral Service Licens	90		2. Name and Address of				Tiginia
Ba	Dec Period		1 alexandria	adates		501 Sandy Spri				
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ncephalopathy	,				Onset and Death 4 days
	/Medical		resulting in death)		a consequence of):	/				+ days
	Examiner		Sequentially list conditions	Cardiac						
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of).					
	and I-trans	хаш	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
90	ficate be executed physicien and s the burial-transit	m m			a 55/155425/165 51).					
68760,	ficate phys s the	edicai								
Box (		/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of deli	very
ă	death certi e attending ed for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
<u>Р</u> О	t the by the	hys	9 □ Unknown	9⊡ Unknown						
of Vital Records, F	The law requires that the tte has been signed by th bage 2 should be detache	ρ	Part II. Other significant conditions con Lung Cancer	ntributing to death be	ut not resulting in the u	nderlying cause given in	n Part I.		cco use contribute to 2 □ No 3 ☑ Pro	
S	law rec as bee 2 shou	jete	Intestinal Obstructi	on				24a. Was an	24b. Were au	topsy findings available
æ	The la te ha	Completed						autopsy performe 1 Yes 2	d? death?	completion of cause of
ita	rtifica	0	25. Was case referred to medical			26	. Place of Death	(Check only one)	A110	20,10
<u>_</u>	Attending Physicien: ir death. ector: After this certifica by the funeral director; i	ToB	examiner? 1 ☐ Yes 2 🔯 No	lospital:	nt 2 ER/Outpatier	nt 3□ DOA Other:	4 🗌 Nursing Hom	ne 5 🗆 Residenc	ce 6 ⊡Other (Spec	cify)
U O	ng Pl		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injui	ry 28b. Time o v Year) Injury	Work?		8d. Describe how	injury occurred	
Sio	tendi leath. for: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				2 🗆 No			
Division	al or Atteno a after death I Director: d in by the	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. (Specify)	reet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 11 Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner/sta	examination and/or in	h occurred at the time, ovestigation, in my opinion	date and place, a	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	W	1	29c. License nu	ımber	29d	. Date signed (Monti	n, Dey, Year)
			> 1 Salle	XII hi	llini.	20562		Ma	rch 2, 2006	
			30. Name and address of person who	mpleted cause of d	eath (Item 23a) (Type,	Print)				
			Barry J. Levin, MD 10	215 Fernwoo	d Road Bethe	esda, Maryland	20817			
	Sta Registr		31. Date filed (Month, Day, Year)	637	ar's Signature	1.6. To				

	-	1 - For State of Maryland / Departm	nent of Health and M cate of Death		ene 0 0 6	06475
Physicia /Medic	_	1. Decedent's Name (First, Middle, Last)  DOROTHY: BAILEY		2. Date of Death Month Mench	Day Year 2006	3. Time of Death
Examine Funeral	er	Frederick Villa Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H U Mor	Catonsville  Catonsville  Inder 1 Year   If Under 24 Hrs. Iths Days Hours Min.	8. Date of Birth (Month, Day, Sept.15	9 Birtl	imore place (State or Foreign untry) York
Director **	or.	113-10-3263   96   97   96   97   96   97   97   97		Sept.15	,1909 New	10d. Inside City Limits 1 ☐ Yes 2 🖺 No
with the M 3a or 28a-f	Direct		f. Zip Code 21228	10	g. Citizen of What Co USA	
Baltimore, Maryland 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Exacultar must be notified at once.	d by Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No	Decedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto es 2 170 Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B	
Baltimore, Maryland 21215-0036  permit. Pages I and 2 should be filed within 72 hours atl  Oppariment of Health and Mental Hygiene.  mportant: if Item 27 is marked other than "natural", or  nny injury or other traumatic event, the Madical Event	Completed	(Specify only highest grade completed) (Give kind of		ing	Educatio	
arylanc should be fi and Mental H s marked ot umatic ever	To Be	Unknown	Unkno			lip Code)
more, Mi ages 1 and 2 nnt of Health a t: if Item 27 is y or other tra	-	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, crematory	or other place)	Date 2	le, Maryla Oc. Location - City or Wrightstow	Town, State
Baltir permit. P Departme Importan any injuri		21. Signature of Funeral Service Licensee 22. Nam Fu	ne and Address of FacilityStell neral Home of ( Edmondson Aver	cling Ash Catonsvil nue; Cato	iton Schwal le, Inc. onsville, N	Mitzke (D. 21228
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease or complications that cated the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	noniA	or respiratory arres	st,	Approximate Interval Between Onset and Death
876( cete be chysicie the bur	Physician/Medical Ex		pic pregnancy or (specify)		23d. Date of deli	very Day Year
cords, P.O. w requires that the d s been signed by the should be deteched	2	Part II. Other significant conditions contributing to death but not resulting in the underly  HWERTEN LION	ing cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
al Reco	Completed	CORONARY ARTERY DISEASE		24a. Was an autopsy perform 1 \( \text{Yes} \) 2	prior to c	topsy findings available completion of cause of
hyei hyei his c	stion: To Be	25. Was case referred to medical examiner?  1	DOA Other: 4 V Nursing Ho 28c. Injury at Work?	th Check only one ome 5 Resident 28d. Describe how	nce 6 □Other (Spec	sify)
Divisio Hospital or Attendi 24 hours after death. Funerel Director: A tely filled in by the ft	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)		City or Town,		
To the Hospital within 24 hours a To the Funeral t completely filled	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occur 2 ☐ Medical Examiner: On the basis of examination and/or investigated and manner stated.  29b. Signature and title of certifier	ared at the time, date and place, ation, in my opinion, death occurred.  29c. License number	red at the time, dat	use(s) and manner as te and place, and due d. Date signed (Montt	to the cause(s)
1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N.B. VELLANKI 885c, COLUMBIA 100 Paykw	·			
Stat Registra		31. Date filed (Month, Day, Year)  MAR 0 6 2006  32. Registrar's Signature	E			

			1 - For State Registrar	State of I	Marylan		artmer rtificat					Reg. N	UUO	06476
	Physici		1. Decedent's Name (First, Middle, La Elizabeth Caro		er						2. Date of De Month March	ath Da	ay Year	3. Time of Death  2:50 P.
1	/Medic Examin	_	4a. Facility Name (If not institution, gir	ve street and number	ər)				Location o		march	40	c. County of Deat	
	E		Brightview Ass			last birthday)	4	tonsv r 1 Year	ille If Under:		8. Date of Bir	th	Balti 9. Birt	more hplace (State or Foreign untry)
	Funeral Director		212-10-3270	1□M 2∏F	94	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year	1911 Ma	
	/land		Usual Residence of Decedent  10a. State  10b. County		10c. Cit	y, Town or Lo	ocation					-		10d. Inside City Limits
	e Mar	ctor	Maryland Balt	imore		Catons	ville	2						1 ☐ Yes 2 🙀 No
	with th	Directo	10e. Street and Number					o Code					itizen of What Co	untry?
	eath v	eral	912 S. Rolling F	load 12. Was Decede	nt Ever in U	S. 13		21228		nin? (Spe	cify Yes or No	USA	14. Race - Ame	ncan Indian.
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itema 23a or 28a-f ehow event, Ita Medical Examinar must be retified at	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1  Yes 2 If Yes, Give Year or Date	s? No		If Yes, spe	cify Cuba	Specify:	, Puerto F	lican, etc.)		Black, White Specify: Whi	e, etc.
21215-0036	72 hours	ted t	15. Decedent's E (Specify only highest gi	ducation		16a. Dece			ition during most	t of workin	na .	16b. l	Cind of Business/	Industry
21	within 7 iene. than "r	mple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT L	ise retired,	)	OI WOIN	9			
2	filed w Hygie other ti	e Co	12 17. Father's Name (First, Middle, Las	1)		Payr	011 (	Clerk		r's Name	(First, Middle		oco Oil	Corp
Maryland	hould be id Mental marked o	To Be	J. Harry Bader						Caro	line	Т. Но	fmaı	nn	
lary	and and sum	Γ,	19a. Informant's Name/Relationship				•						or Town, State, Z	
	s 1 and 2 if Health Item 27 other tru		Caroline E. Alde	r Niece		207 Place of Dispo			g Roa		atonsv		ocation - City or	
nor	0 O		1 XBurial 2 ☐ Cremation 3 {		to C	emetery, cre	matory or	other place			- 4		lawn, M	
Baltimore,	in jort		4 □ Donation 5 □ Other (Special Signature of Pyneral Service Lice	-	201	2:	2. Name a	nd Addres	s of Facilit	Ster	ling A	shto	n Schwal	b Witzke
ñ	Den Popper		Clore	KALI		1	Funer 630 H	ral H Edmon	ome d dson	of Ca Aven	tonsvi ue: Ca	11e,	, Inc. sville, J	MD 21228
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause on each	sed the deat									Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_aD/	east	Caro	'er							yeas
	Examiner		1	Due to (or	as a conseq	uence of):								
rs(	z _ <2	ner	Sequentially list conditions, if any, leading to him adiato cause. Enter Underlying Cause (Disease or injury	b. Directo (or	as a nonsec	uanda of):				-				
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C										
8760,	ate be executed hysician and the burial-transit		rossing in dozin) East	Due to (or	as a conseq	uence of):								
687	ificate g phys as the	edic		_ d										
Вох	eath certific attending p I for use as I	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			∃Ectopic p	regnancy					23d. Date of del	•
.O. E	that the dea ed by the at detached fo	Physician/Medical	in the past 1 <b>3</b> months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnan 9□Unknow	t at time of d		Other (s		-1000	7.7.			Month	Day Year
ο.	Se us	by Ph	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying	cause give	in in Part I.		23e. Did 1			the cause of death?
ord	w require been si should t										1 🗆	Yes 2		obably 4 Unknown
Records,	he law e has b ige 2 sl	Completed										psy ormed?	prior to death?	stopsy findings available completion of cause of
Vital		0	25. Was case referred to medical		-2001				26. Place	of Death	1 Yes	210 N	o 1 ☐ Yes	2□ No
of V	Physician: this certificant ral director,	To B	examiner? 1 ☐ Yes 2 No			ER/Outpatie	nt 3 D	OA Othe	or: 4 □ Nu	rsing Hon	ne 5 mesi	idence	6 □Other (Spec	cify)
o uc		lon:	27. Mann of Death 1 Natural 5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury		28c. Injury Work			8d. Describe	how inj	ury occurred	
Division	I or Attendi after death. Director: A	ficat	2 Accident investigation 3 Suicide 6 Could not determine	De Con Disco of	Injury - At he	ome, farm, st	M reet, factor		/es 2 □ l		8f. Location (	Street a	und Number or Ru	ural Route Number,
Ö	tal or A s after al Direct ed in by	Certification:	4 Homicide determined	building,	etc. (Specif	(y)					City or To	wn, Sta	te)	
	To the Hospital or Attending within 24 hours after death.  Yo the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medicaf Exa	hysician: To the be mider: On the basi and manner	s of examina	owledge, deat ition and/or in	h occurred ivestigation	at the time n, in my op	e, date an pinion, dea	d place, a th occurre	nd due to the ad at the time,	cause( date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within comp	Me	29b. Signature and title of certifier -	1.			29	c. License	number			29d. D	ate signed (Monti	h, Day, Year)
P			1 from	fan	9			1)5	+16	9		M	ach 6,	2000
1	)		30. Name and address of person who	completed cause of	of death (Item		Print) Ca	Son	M	212	diy.	D	ach 6, i	wy. MD
	Sta Registi		31. Date filed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )  MAR 0 6 201	100	istrar's Signa	ature	Ma							

Jeffr 06-01	-	sha	ll Beall Unpend item	ise Type or # 23a PII, 27 State o	Print in 1	Black In	delible Ir	nk. Ens	sure Al	l Copies	Are	Legible.		
rn			1 - For State Registrar	State o	if Marytar		artment o rtificate o				giene Reg. No.	/11116	06	477
	57.		Decedent's Name (First, Midd.	le, Last)	-					2. Date of De.	ath		3. Time o	
	Physici /Medio		JEFFREY MA	ARSHALL	BEALL					March	Ola,	2006	6:10	Рм
6	Examin		4a. Facility Name (If not institution 3500 Block Ash	-	mber)			timore	e		4c.	County of Dea	th	
122	Funeral Director		5. Social Security Number 213-76-2980	6. Sex 1∑M 2□ F	7. Age (In yrs. 46	. last birthday) Yrs.	If Under 1 Ye Months Da			8. Date of Bird (Month, Da Sept. 1	y, Year)	Co	hplace (State ountry) aryland	
	Maryland -f show	or.	Usual Residence of Decedent  10a. State 10b. County  Montral and A11		10c. Ci	ity, Town or Lo							10d. Inside C	City Limits
	28a-f	Funeral Directo	Maryland All	Legany		Cumber	10f. Zip Coo	de			10a. Citi	izen of What Co	l	
	3e or	<u>=</u>	12410 Eva Driv	7e				2150	2.			U.S.A		
	death	nere	11. Marital Status		edent Ever in U	J.S. 13.	Was Decedent If Yes, specify (	of Hispanic	Origin? (Spe	cify Yes or No	-	14. Race - Ame Black, Whit	nican Indian,	
9036	hours after death with the Marylan tural', or items 23e or 28e-f show al Examinar musi be notified at	þ	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	nied 1 ∐Yes If Yes, Gi	2 XNo		1 ☐ Yes 2 🔀			ritoan, etc.)		Specific	nite	
2-0	27 5 3	etec		nt's Education ist grade completed)		(Give	dent's Usual Oc kind of work do	one durina n	nost of worki	ng	t6b. Ki	ind of Business	Industry	
121215-0036	permit. Pages 1 and 2 should be filed within 72 Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Medic 90cs.	Completed	Elementary/Secondary (0-12)  10 years  17. Father's Name (First, Middle,	College (	1-4or 5+)	iire.	Carpe	nter	ab ada Na -	/Finn A Adiodolo	Ada ida -	Constru	ction	
Baltimore, Maryland	ntal H ed ot	Be		Beall						(First, Middle, enevieve		-		
<u> </u>	shoulk nd Me mark imatk	၉	Roby Emory  19a. Informant's Name/Relations			19b. Maili	ng Address (Str					ealover		
Σ	and 2 selth at n 27 is		Grace G. Lewis	(mothe	er)	12410	) Eva Di	rive	Cumber	rland.	Mary	land 21	502	
ore,	es 1 a of Her		20a. Method of Disposition 1 XBurial 2 Cremation		20b. i	Place of Dispo	sition (Name or matory or other	f		ate		ocation - City or		
ij	Pag ment ant: I		4 Donation 5 Other (5		Oa		Cemete		3-8-		Bal <sup>1</sup>	timore,	Maryla	and
3ait	permit. Departr Importu any Inji		21. Signature of Funeral Service	Licensee		M	2. Name and Actitchell	ddress of Fa -Wied	efeld	Funeral	1 Hor	me, Inc		
	40240		23a. Part1. Enter the disease, o	complications that	eaused the dea		0000 10	TV VO	au Da	TETHOT	علالم	arýland	21212 Approxima	
			shock, or heart failure. List	t only one cause on e	each line.		ter the mode of	dying, such	as cardiac o	i respiratory ar	irest,		Interval Be Onset and	tween
A.	Physician /Medical		disease or condition resulting in death)	_ a	tic intox (or as a consec									
	Examiner		and the second second		,	,								
	ם ב	Iner	Sequentially list conditions, and leading to the cause. Enter Underlying Cause (Disease or injury	Due to	or as a cons	uence off:								
	ficate be executed physicien and is the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consec	augnes of):								
60,	be ex icien burial	_		Due to	(Or as a consec	quence oi).								
387	ficate phys s the	odle		d										
Box 68760	Jeath certifica attending ph for use as t	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		~~~					23d. Date of de	ivery	
P.O. B	The law requires that the death certificate be executed site hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transi	Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ointh 2 Teta nant at time of c own		⊒Ectopic pregna ⊒ Other (specify				100	Month	Day	Year
ت.	signed by	y Ph	Part II. Other significant conditi	ons contributing to d	eath but not res	sulting in the u	nderlying cause	given in Pa	ırt I.	23e. Did to	obacco u	use contribute to	the cause of	death?
Division of Vital Records,	quires n sigr uld be	q pe	Cocaine use							101	Yes 2[	□No 3□Pi	obably 4 💢	Unknown
o O	aw requir is been si 2 should I	plet	cardiomegaly							24a. Was		24b. Were at	topsy findings	available
<u> </u>		No.	Hypothermia								rmed?	death?	completion of a 2□ No	2020 01
/ita	Attending Physician: Th r death. sctor: Atter this certificete by the funeral director, pag	Be (	25. Was case referred to medical examiner?							(Check only o				
<u></u>	Physi this c	<sup>L</sup>	1 Ves 2 No		Inpatient 2		" OD DOX 1					6 Other (Spe	cify) at s	cere
uo	iding Phys th. : After this of tuneral dir	tlon	1 □Natural 5 □ Pendi	ng 28a. Date (Mon igation Fnd 3/	th, Day Year)	28b. Time o Injury Fnd 6:0	1	njury at Work? 1 ∐ Yes 2	<b>7</b> 71.1.	28d. Describe t	now injur	y occurred		
isi	Attenderall deatlers:	flca	3 ☐ Suicide 6 ☐ Could	not be		1	reet, factory, offi			nk 28f. Location (5	Street an	d Number or Ri	ıral Route Nun	nber,
Ş	ator / s after I Dire	Certification:	4  Homicide determ		ing, etc. <i>"(Speci.</i> <b>under</b> a					City or Tov Baltimore	wn, State,	) 3500 B1k	. Ash St	•
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the Examiner: On the b	best of my kno	owledge, deat	h occurred at th	e time, date ny opinion, d	and place, a	and due to the	cause(s)	and manner as	stated. to the cause(s	s)
_	To the	Ā	29b. Signature and title of certifie				29c. Lic	ense numbe	9r		29d. Dat	e signed (Mont	h, Day, Year)	
			I him hi	(Jun)				0.0	C.M.E.		Marc	h 02, 2	.006	
	3)		30. Name and address of person	who completed caus	se of death (Ite	m 23a) (Туре, 111	Print) Penn St	treet,	Balti	imore,	Mary	land 21	201	
¥	Sta		31. Date filed (Month, Day, Year,	32.	logistrar's Signa	ature	ank a							
Y 4.	Registr	ar	MAR 0 6	2005	Market 1	or Ag								

			1 - State of Maryland / I	Department of Health and N Certificate of Death	fental Hygie	2000	06478
	0		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Qay Year	3. Time of Death
	Physici /Medic		HAROLD BROOKS.			1 2006.	9.40 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Northwest Hospital Center	Randallstown		Baltimore	3
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	nthday) If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthp	lace (Stete or Foreign
	Director		219-03-4172 <sup>1</sup> ₹ <sup>M 2□ F</sup> 88	Yrs.	Oct. 13,1	917	MD
	pur 🛦 :		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town	m or Location			Od. Inside City Limits
	shor	5					1 ☐ Yes 2 ☐ No
	Ne M	Director		dallstown			
	Mith to a		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	ntry?
	s 23	Funerai	6 Susanna Court  11 Marital Status 12. Was Decedent Ever in U.S.	21133	acifu Vac as Na	USA. 14. Race - Americ	an tadion
	lterr Inerr	Ë	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
336	urs af		3 Widowed 4 Divorced   If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: Whit	- Δ
ŏ	filed within 72 hours after death with the Maryland Hygiene the than "natural", or Items 23a or 28a-f show with the Maulical Examiner must be notified at	Completed by	15. Decedent's Education 16a	. Decedent's Usual Occupation	16	b. Kind of Business/In	
21215-0036	nin 7.	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ring		ŕ
2	d with	JO III		Mechanical Engineer		Engineeri	ng
b	al Hy lothe	Be (	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Sumame)	
/la	Ment Ment arked	To	George Brooks	Ada	Sorden		
Maryland	and and is my			b. Mailing Address (Street and Number or Run			
	of Health of Health litem 27 i			812 Wheeler Brive, T		y, Texas 7	5056
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 3 ☐ Removal from State 20b. Place of cemeter	f Disposition (Name of ry, crematory or other place)	Date 20	c. Location - City or To	wn, Slate
Ě	Pages ment of I ant: If its ury or o			oll Cremation 3/6/0	)6	Hampstead,	MD
ä	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  The Marylest Examiner must be notified at any injury or other traumatic event, the Marylest Examiner must be notified at any injury or other traumatic event, the Marylest Examiner must be notified at any injury or other traumatic event, the Marylest Examiner must be notified at any injury or other traumatic event, the Marylest Examiner must be notified at		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	11824	Reisterst	own Road
<u> </u>	205 # 9		Mans & Come	Eline Faneral Home		erstown, Mi	21136
			23a. Fart1. Enter the disease, or complications that caused the leath. Do hock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between
1.0	Physician		Imm date Cause (Final dispesse or condition	CHRONIC OBSTRU	G SVIES	ULMENARY	Onset and Death
	/Medical Examiner		(esúlting in death)  Due to (or as a consequence			MC III	- Cizenae
Н	Examiner	_	Sequentially list conditions, b.				
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):			
	cate be executed physician and the burial-transit	Examiner	that initialed events c. Due to (or as a consequence	of):			
8760,	be e sician buria						
587	ficate phys	edicai	d				
×	at the death certifi I by the attending patached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	irv
. Box	death a atte	iciai	in the past 12 months?  1  Yes 2 No  1  Yes 2 No	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
o.	the cachecachec	nysi	9 Unknown				
٠, ح	res that igned b	by P	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
<u>rd</u> s	quire n sig uld bu	d b	Anemia		1 ☐ Yes	2 □ No 3 □ Prob	abiy 4 Unknown
Records,	The law requires that the te has been signed by thoage 2 should be detache	Completed			24a. Was an	24b. Were auto	osy findings available
Be	The lav	шо			autopsy	d? prior to cor death?	npletion of cause of
ta		Be C	25. Was case referred to medical	26 Place of Deat	1 Yes 2 L	No 1 ☐ Yes	2 No
>		.0	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Inpatient 2 ☐ EP/O	Othor		e 6 Other (Specify	()
ō	g Phys er this eral dir	E	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at	28d. Describe how		,
Ö	ndin ath. r: Aft e fun	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	injury Work? M 1 Yes 2 No			
Division of Vital	Atta	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	trm. street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rura	l Route Number,
	s after sall Dir	Cert	building, atc. (opecity)		Oily or Town, o	nate)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edicai (	29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination are	e, death occurred at the time, date and place,	and due to the caus	se(s) and manner as st	ated.
	To the H within 24 To the F complete	edi	one) and manner stated.				
	To To	Σ	29b. Signature and title of certifier  Mehla M.D.	29c. License number	1	Date signed (Month,	- 1
				D41410.	Wo	rch or,	2006.
			30. Name and address of person who completed cause of death (Item 23a)	4 30611100	MEHTA		
			MATHWEST HISPITAL CENTER	KANDTILLSTOWN	MO "	31133	
:	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 6 2006	Agerte .			
	negistr	aı	MAK O G LUUG MAGA				

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Vital

o to

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item: 20b per F H C-853 3/6/06 rep
State of Maryland Department of Health and Mental Hygiene 110

06479 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** February 28, 8:34 P M DONT'E BELLAMY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 215 06 6053 22 Yrs. Director Jan. 27,1984 MD. Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1650 DARLEY AVENUE 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Never Married 2☐ Married 1 ☐ Yes 2 ☑ No Specify þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other then "n College (1-4or 5+) Elementary/Secondary (0-12) 10TH UNEMPLOWED N/A17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny lighty or other treumatic event 9DC8. 18. Mother's Name (First, Middle, Maiden Sumame) Be ERVIN COKELEY LESLIE GUZMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE GUZMAN / MOTHER 1650 DARLEY AVE. BALTO, MD. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem Pk

KING MEMORIAL PK. MAR. 8,20(6) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State OWINGS MILLS, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a GUNSHOT WOUNDS OF 70.850 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). The law requires that the death certificate be executed anding physicien end use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 autopsy performed? certificate 1X Yes 2 No 1 Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2000 Inpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXes 2 No ieral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; Hospital or Attending 1 Natural 5 Pending SUBTECT WAS SHOT death. 7:55 P M investigation 2/28/06 1 Yes 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State), 1600 BLK & 27 ST, BACTING RE, MD 4 Homicide STREET 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MOS O.C.M.E. March 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO 111 Penn Street, Baltimore, Maryland MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 0 6

			1 - State Registrar C	partment of Health and Mental Hygiene ertificate of Death	06480
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Edward William Chabot  4a. Fecility Name (If not institution, give street and number)	2. Date of Death Month Day Yea March 05 Zo  4b. City, Town, or Location of Death 4c. County of De	06 14 30 M
	Examir	ner	Howard County General Hospital	Columbia Howard	
	Funeral Director		5. Social Security Number 577-10-4392  G. Sex  IMM 2 F  7. Age (In yrs. last birthda 92 Yrs.  Usual Residence of Decedent	Months Days Hours Min. (Month, Day, Year)	irthplace (State or Foreign Country) cyland
	ith the Maryland or 28a-f show	tor	10a. State 10b. County 10c. City, Town or MD Howard Elkridge	Location	10d. Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28a 81 be not	al Direc	10e. Street and Number 5991 Augustine Ave.	10f. Zip Code 10g. Citizen of What 0	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Fyes, 2 No If Yes, Give Year or Dates: 1936-51	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:  Specify: W	
21215-0036	filed within 72 ho Hygiene. other than "natur	Completed	(Specify only highest grade completed) (Gir	sedent's Usual Occupation Le kind of work done during most of working L DO NOT use retired)  16b. Kind of Busines U.S. Gover	
Maryland ?	2 should be filed and Mental Hygis Is marked other aumatic event, I	To Be C	17. Father's Name (First, Middle, Last) Edward F. Chabot	18. Mother's Name (First, Middle, Maiden Surname) Katie Shea	
	1 and 2 sho Health and I Iem 27 Is me other traums			iling Address (Street and Number or Rural Route Number, City or Town, State 1991 Augustine Ave., Elkridge, MD 210	
Baltimore,	permit. Pages 1: Department of He Important: If iten any Injury or oth		t√ Burial 2 □ Cremation 3 □ Removal from State   cemetery, ci	position (Name of 903/10/06 Date 20c. Location - City of 900 Date	
Balt	permit. Pages Department of Important: If I any Injury or once.		1 Cull Lips 11010	22. Name and Address of Eacility Try L. Kautiman Funeral Home at Meadowridge M 250 Washington Blvd., Elkridge, MD 21075	amorial Park, I
	Pnysician /Medical Examiner	er	23a. Cart I. Enter the disease, or conditions that caused the death. Do not essence, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause that Jarying Cause (Disease or injury)  Due to (or as a consequence of):  Due to (or as a consequence of):	0	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examine	Cause Disease or injury Cause Disease or injury that initiated events resulting in death) Last  C		
P.O. Box 6	that the death certificated by the attending placed for use as t	Physician/Medical		☐ Ectopic pregnancy 23d. Date of d Month	elivery Day Year
	The law requires that the tite has been signed by thoage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	M	to the cause of death?  Probably 4 DUnknown
Vital Records,		Completed		24a. Was an autopsy prior to performed? death?	
of	ing Physici After this ce uneral direc	ation: To Be	25. Was case referred to medical examiner?  1	of 28c. Injury at 28d. Describe how injury occurred	ecify)
Division	Dirig of	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office  28f. Location (Street and Number or F City or Town, State)	Rural Route Number,
	Fur the	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dead of the best of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner a investigation, in my opinion, death occurred at the time, date and place, and di	is stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Mor	
	V		30. Name and ad s. of person w o completed cause of death (Item 23a) (Type Richard Add M.O. 5	DO059283 March 755 Cedar Lane, Columbia	Md 2104
	Sta Registr	-51	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ske)	

			1 - For State Registrar	State of M	Maryland /		artment rtificate			nd Me		iene	6	064	8
	Physici	an	1. Decedent's Name (First, Middle	0/	afm	d de				2	. Date of Deat Month	h Day	Year	3. Time o	of Death
	/Medic		William								12-2	7 20	206	3.	30 PM
	Examin	er	4a. Facility Name (If not institution	-			- partie	- 1	ocation of			4c. County			
			5. Social Security Number	4038, F21	Age (In yrs. last		If Under 1		If Under 2		. Date of Birth				or Foreign
	Funeral Director		179-40-6481	1 🕅 M 2 🗆 F	59	Yrs.		Days	Hours	Min.	(Month, Dey, Aug. 29	1946	Cou	place (State ntry) PA	ar r araigir
			Usual Residence of Decedent								tag. Es	1310			
	arylar show	Ŀ	10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside C	City Limits 2√∑No
	with the Maryland e or 28a-1 show be notified at	Director		ltimore			100 -		<u>Baltir</u>	more					- ZX1110
	death with the Maryland ms 23e or 28a-f show tinged by redificed at	급	10e. Street and Number 3701 Twin Lakes	C+ #122			10f. Zip (	ode	212	11	14	0g. Citizen of \		ntry?	
	leath	Funerai	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13.	Was Decede	ent of Hist			fv Yes or No-	14. Rac	USA e - Ameri	can Indian,	
	after des or items	Fun	1 ☑ Never Married 2 ☐ Marri	ied Armed Forces	s?					Puèrto Ri	fy Yes or No- can, etc.)	Blac	k, White,	etc.	
2-003p	hours after tural', or ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2	⊠ No	Specify:			Specify	⁄∵ Bl	ack	
ဂ်	72	Completed	15. Decedent (Specify only highes	's Education at grade completed)	11	(Give	dent's Usual kind of work	done du	ion ring most o	of working		16b. Kind of B	usiness/Ir	dustry	
7	within ene. than "	dui	Elementary/Secondary (0-12)	College (1-4o	r 5+)		<i>po not</i> úse M Spec		i c+			FFMA			
ט ט	filed Hygid Sther ent,		17. Father's Name (First, Middle, I				n Spec			's Name (/	First, Middle, N	1 4 1 17			
	lid be lental ked c	To Be	Dudley D.	Chatman Sr	•				Mati	tie	L.	Wilso	n		
az	s mail		19a. Informant's Name/Relationsh	nip (Type, Print)	1	9b. Mailir	ng Address (	Street an	d Number	or Rural F	Route Number,	City or Town,	State, Zij	Code)	,
Σ	and and alth alth alth alth alth alth alth alth		<u> Iris Rodgers</u>			3701	Twin	Lake	s Cou	urt //	123, B	altimor	e, M	2124	14
	ges 1 an t of Heal If Item 2 or other		20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 ☐Removal from Stat	e Cente	нөгу, сгөг	natory or ou	ier piace)	Ma	Dat arch	$\Omega I$				
= '	artment ortant: injury		4 □ Donation 5 □ Other (S	pecify)	Roun	d Hi	11 Cen	neter	`y   '''	arch 200	6 T _ I	Elizabe	th,	PA	
Dail	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service I	loop of		22	3111 Name and	Address 10unt	of Facility Cain F	St Road,	alling: Pasade	s Funer ena, MD	211 211	ome, F 22	, A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications tha usonly one cause on ach	ed the death. D line.	o not ent	er the mode	of dying,	such as ca	ardiac or r	espiratory arre	st,		Approxima Interval Be	tween
f	nysician		Immediate Cause (Final disease or condition	- a Arthe	eroscl.	eso	tic.	Cara	diov	lasc	ular	disea	se	Onset and	Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Artherosclerotic CardioVascular disease pue to (or as a consequence of):  Sequentially list conditions  b. Siabetes mellitus											5	
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	e (e.s. is a consequent	17 ] @ ce of):	aulu	->					-		
	d d ansit	Examine	if any, leading to immediate cause. Enter Underlying Causa (Liseas) or in it is that initiated events	HYP	ertes	15	ion							15	•
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Õ X	as as	/Med	IF FEMALE:	22a H van autona	o of programs										
Š P	death c e attended for us	hysician/Me	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal dea at time of death		Ectopic pre						te of deliv nth	-	Year
j į	y the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	21 11110 01 00211	3	1011161 (3po	City)							
λ, T	w requires that the death cer been signed by the attendir should be detached for use	by Pt	Part II. Other significant condition	ns confributing to death	but not resultin	g in the u	nderlying car	use given	in Part I.		23e. Did tob	acco use cont	ribute to t	he cause of	death?
cords	requires een sign hould be	ed b	yiabetic .	ulcers							1 <b>/X</b> Ye	s 2□No	3 Prol	oably 4 🗌	Unknown
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r ,	sician: The law s certificate has b irector, page 2 s	Com									perform	red?	death?		04430 31
Vital	cian: ertific actor,	Be (	25. Was case referred to medical examiner?							-	Check only one				
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ב ה	After After funer	tion	1 XNatural 5 ☐ Pending	g 28a. Date of In (Month, D	ay Year)	Injury	M 28	c. Injury a Work? 1 □ Ye	u es 2.∐No		d. Describe ho	w injury occurr	90		
DIVISION	deatl ctor: y the	fica	3 Suicide 6 Could n	not be 28e. Place of li	njury - At home,	, farm, str					. Location (Str		er or Rur	al Route Nur	nber,
	al or s s after if Dire	Certification;	4 Homicide	building,	etc. (Specify)						City or Town	State)			
:	To the hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	cai	(Check only 2 Medical I	g Physician: To the bes Examiner: On the basis and manners	of examination	and/or in	estination i	n my onin	nion death	occurred	at the time da	te and place	and due t	n the cause/	s)
:	vithin To th compl	Me	29b. Signature and title of certifier	1 /			29c.	License r	number		29	d. Date signe	d (Month,	Day, Year	
	-		Muser-	- anoy	P		1	502.	3+2	4		03/0	3/2	00B	
1	2		30. Name and address of person of DUSEGUA	who completed cause of	death (Item 23)	a) (Type,	Print) 5:	310 i	dall.	cour	In, m	D 2113	33		
	Sta Registr	te ar	29b. Signature and title of certifier  30. Name and address of person of the person of	2006 32. Régis	strar's Signature	A.	ande			-	•				

			1 - For State Registrar	State of Maryla		artmen rtificat					giene Reg. No.	006		06482
	Physic	an	Decedent's Name (First, Middle, Last,     Mary Virginia Cove							2. Date of Dea Month		,Y	ear 11/16	3. Time of Death
	/Medi Examir	cal	4a. Facility Name (If not institution, give Saint Joseph I	street and number)	iter	4b. City,	Томп, о	Location	of Death			County of	Death	02:00 FM
Ī	Funeral Director		Social Security Number		. last birthday)	If Under Months		If Under Hours	Min	8. Date of Birtl (Month, Day ugust 2	Year)		Coun	lace (State or Foreign try) 1and
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation							11	0d. Inside City Limits
	Maryli -f eho	ţ	Maryland Baltimor		Phoenix								-   "	1 ☐ Yes 2 X No
	with the Marylar 3s or 28s-f show	i Direc	10e. Street and Number 13403 Redcoat Lane			10f. Zip	Code				_	zen of Wha		*
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or items 23e or 28e-f show other treumatic event, the Mudical Examiner must be notified at	by Funeral Director	11. Maritat Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ₩ No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 \( \text{Yes} \)	offy Cuba	ispanic Ori in, Mexicar Specify:	gin? (Spec	cify Yes or No- tican, etc.)		14. Race - Black, Specify:	White, e	
21215-0036	within 72 ho ene. than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	life.	kind of wo DO NOT us	rk done i se retired	durina mos	t of workin	g		nd of Busir		dustry
land 2	2 should be filed v and Mental Hygie is merked other t reumatic event, III	To Be Co	12 17. Father's Name (First, Middle, Last) John Ostendorf		a	rtist			er's Name	(First, Middle, King		artwo Sumame)	LK	
Maryland	d 2 shou th and M ?7 is mar treumati	1	19a. Informant's Name/Relationship (Ty Victor Covey/husba	•	19b. Mailir			and Numbe	er or Rural	Route Number		7 Town, Sta	_	Code)
Jore,	ages 1 and 3 nt of Heelth : If Item 27 or other tre		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	20b.	Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther plac	θ)	Da	ite	20c. Lo	cation - Cit	y or To	
Baltimore,	permit. Peges 1 Department of H Important: if its eny injury or ot once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			. Name an Mi	d Addres		ledef	,2006 eld Fur Baltin	nera	1 Hom	e,	Maryland Inc. 212
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the dealer cause on each line.  METASTATI  Due to (or as a consect	C BRE	er the mod	e of dyin	g, such as						Approximate Interval Between Onset and Death
68760,	ficate be executed physiclen and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	· · · ·									
P.O. Box 6	death certii e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	aldeath 3□	Ectopic pro Other (sp.					2	3d. Date o Month		ry Day Year
	es the igned be de	þ	Part II. Other significant conditions con OBSTRUCTIVE JAU		sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	1	1		e cause of death?
Vital Records,	The ate h page	Completed	THROMBOCYTOPENIA	A						24a. Was a autops perfore 1 Yes	SV	24b. Wer prio dea 1 🗆	r to com	sy findings available optetion of cause of
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?				Tai		of Death	Check only or	/	-		
ot		<u>۲</u>	1 Yes 21 No	ospital: 1 Inpatient 2 2	ER/Outpatien 28b. Time of			4 🗀 140		e 5 🗌 Reside			Specify	)
ion	Attending r death. ctor: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	8c. Injury Work 1 🔲 ۱	:? ∕es 2 ∐ 1		od. Describe in	JW III JULY	OCCUITED		
Division	el or Attencs after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre fy)	eet, factory	, office		28	3f. Location (Si City or Town		d Number o	r Rural	Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in Director C	edical	one) 2½   Medical Examir	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred a	at the tim in my op	e, date and pinion, deat	d place, ar	nd due to the ca	ause(s) ate and	and manne place, and	er as sta	ated. the cause(s)
	or tiry not moo	Σ	29b. Signature and title of certifier			,	License	number 7254		2	9d. Date	signed (A	onth, E	Day, Year)
			30. Name and address of person who co	mpleted cause of death (Iter										
	Sta Registr		DR LIM, M.D. 7  31. Date filed (Month, Day, Year)  MAR 0 6 201	32. degistrar's Signa		TOWS	ON,	MAR	YLAN	D 2120	14			

			1 - For State Registrar	State of Marylan		artment of I			giene 006	06483
	Dhu	oisian	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
		sician edical	John H. Coburn					March	3, 2006	1:54 a <sup>M</sup>
	Exa	miner	4a. Facility Name (If not institution, give st				or Location of Deatl	ר	4c. County of Dea Baltin	
			Gilchrist Cent  5. Social Security Number 6. Sex	7. Age (In yrs. I	last hirthday)	If Under 1 Year	WSON	8. Date of Birth		thplace (State or Foreign
	Fune Direc			M 2□F 97	Yrs.	Months Days		6/29/	, Year)   Co	ryland
	_		Usual Residence of Decedent					1 0/29/	00 Ha	Tyrand
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Ma	Ş	Md n/a		В	altimor	e			1 No 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code	201	1	log. Citizen of What C	ountry?
3	death with the Maryland	rai	1222 Anglesea S				224		USA	
40	er de	- File	11. Marital Status 12 1 □ Never Married 2 ★ Married	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>	5. 13.1	was Decedent of f Yes, specify Cut	Hispanic Origin? (S pan, Mexican, Puerl	o Rican, etc.)	14. Race - Ame Black, Whi	
Syam	urs aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2DXNo	Specify:		Specify:	<i>l</i> hite
_	5-0030 72 hours after natural, or ite	Completed by Funeral Director	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occu	pation	rking	16b. Kind of Business	
ž	within 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	lite.		during most of wordd)			
3	d Z I Z I filed within Hygiene. other then "	ပ်	10	0	Pain	ter / 1	Paper Ha			Employed
	D B B B	Be	17. Father's Name (First, Middle, Last)	ton Cohumn	Cm			ne (First, Middle, 1 7 Thomps		
•	should not marke	2	Benjamin Huning			no Address (Stree	<u> </u>		r, City or Town, State,	Zin Codel
	Ma Md 2 s ith an		Mrs. Sonya Varga				Court I		, MD 210	
٠	Daltimore, Mar permit. Pages 1 and 2 sh Department of Heatth and Important: if Item 27 is n		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other pla	acel	Date	20c. Location - City or	Town, State
0	Pages Pages Int: If it		1 MBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)				ery 3/6	5/06	Baltimore	e, Md.
2	Baltimore, permit. Pages 1 a Department of Hea Important: If item	*	21. Signature of Funeral Service Licenses				sk Fac Fun		me P.A.	
3	מַבַּבּבּ	one one	Eugene V.	Tartne					imore, Mo	1. 21222
	Hiller		23a. Part1. Ent of the disease, or of mplic shock, or leart failure. List only one	ations that caused the death	n. Do not ent	er the mode of dy	ing, such as cardiad	or respiratory arr	est,	Approximate Interval Between
	Physic	an	Immediate Cause (Final disease or condition				21			Onset and Death
_	/Medi Examir		resulting in death)	Due to (or as a consequ	uence of):					
	Exami		Sequentially list conditions, b.	prevnoni	9					6475
,	ted io	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Dae 10 (01 as a consequ	16/109 01/1.					
	be executed icien and	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					
í	- e s	cal	d.							
	certificate	Medi	IF FEMALE:	124						
,	BOX 08 leath certifica attending ph	Physician/Med	23b. Was decedent pregnant in the past 12 months?	<ul> <li>c. If yes, outcome of pregna</li> <li>1 ☐ Live birth 2 ☐ Fetal</li> </ul>		Ectopic pregnanc	су		23d. Date of de Month	livery Day Year
	. 0 0	Sici	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	eath 5□	Other (specify) _				54,
5 6	r hat y	P.	Part II, Other significant conditions cont	nbuting to death but not resu	ulting in the u	nderiving cause g	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
,0:	0 8 G					, ,		1 🗆 Y	es 2) No 3 P	robably 4 Unknown
17	1 - A	Completed			•			24a. Was a	an 24b. Were a	utopsy findings available
	The lav	d Wo						autops perfor	med? death?	completion of cause of
2		O	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or	2000 1 □ Yes	3 Z NO
and a	OT VITA Physician: this certific	ToB	examiner? 1 ☐ Yes 2 No	spital: 1 Inpatient 2 I	ER/Outpatier	it 3 DOA	then: 4 🗆 Nursing H	lome 5 Resid	ence 6 Other (Spe	ecity) huspiù
2			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	iry at ork?	28d. Describe h	ow injury occurred	
19.	VISION Attending r death. ector: After	cati	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2 □No			
0	DIVISION  I or Attending after death. Director: Afte	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (S. City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director:	20	29a. Certifier Certifying Physi	cian: To the best of my kno	wiedge, death	occurred at the t	ime, date and place	a. and due to the c	ause(s) and manner a	s stated.
H	9 44 P	Medical	(Check only 2 Medical Examinations)	er: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my	opinion, death occu	irred at the time, d	late and place, and du	e to the cause(s)
1 6	To the To the (	N N	29b. Signature and title of certifier				se number		29d. Date signed (Mon	
			Mond	CUL		2	05830	3 6	March 3	2005
			30. Name and address of person who con		23a) (Type,	Print) asker	+ BAIN	wono u	March 3	l
		CANA	31. Date filed (Month, Day, Year)	32 Registrar's Signa			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		7	
	Re	State gistrar	MAR 0 6 2006		Aso	29				

State of Maryland / Department of Health and Mental Hygiene [1] 1 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 950A M March 2006 RAYMOND CARTER /Medical 4a. Facility Name (If not institution, give street and number)
SHAGNES HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore St Agnes If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1X M 2 □ F Yrs. Director 216-34-5125 12-31-1939 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow treumatic avant, the Medical Examiner must be notified at NOXYes 2 □ No Completed by Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with ŏ items 23a 1106 N. DUKELAND STREET 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2√ No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DENTAL TECHNICIAN HEALTH 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be t end 2 should be fi Health and Mental H tem 27 is marked ot FRANCES CARTER PETER RAWLINGS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health at Importent: if item 27 is any injury or other treu 1106 N. DUKELAND STREET BALTIMORE, MD WANDA CARTER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMETERY 3-7-2006 BALTIMORE. MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee Morton 1701-31 LAURENS ST. BALTIMORE, MD 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Opset Ind Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death signed by the at t be detached fo 5 Other (specify) O 9 Unknown 9 Unknown Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute renal failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown cardiomyopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 V No. 1 Yes 1 ☐ Yes of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28h Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Attending 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53249 Physician AMO) gress of person who completed gause of death (Item 23a) (Type, Print)

gress Hospital 900 S. Caton Ave Baltimore 21229 George Hoke Hanes

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Raymond

32. Registrar's Signature

UNK \G	06-1502		for State	Plea				nd / Dep		of H	Ensure A Health and I	•	ygien	9006	06485
	Physici		1. Decedent's Name	e (First, Middle JRAYE	e, Last)	COLE			rimoaic	, 01	Deain	2. Date of D Month Febr	D		3. Time of Death er 006 9:00 PM
	/Medic Examin		4a. Facility Name (/	f not institution	n, give stre	et and number	-)	···	1		or Location of Deat			c. County of D	
			Johns Hop						Balt					n/a	
	Funeral Director		5. Social Security N 212 86 (	226	6. Sex 1 ☐ M X	2□F 7. A	.ge (In yrs.	. last birthday, Yrs.	Months	Days	If Under 24 Hrs Hours Min.	(Month, D	ay, Year	9. 1970	Birthplace (State or Foreign Country)  MD
	and ow		Usual Residence of 10a. State	10b. County			10c. Ci	ity, Town or L	ocation						10d. Inside City Limits
	deeth with the Maryland ma 23a or 28a-f ehow frivet be notified at	ţō	MD.	N/	'A		В	ALTIM	ORE						1 ☐ Yes 2 ☐ No
	ith the or 28s	Director	10e. Street and Nur						10f. Zip	Code			10g. C	itizen of What	Country?
	eth w	ral		KAVON			. =			120				usa	
	io # #	Funeral	11. Marital Status 1 Never Marri	ied 2□ Marı		Was Deceden Armed Forces 1 ☐ Yes 2 E If Yes, Give	?	J.S.   13.			dispanic Origin? (S an, Mexican, Puer Specify:	ipecify Yes or N to Rican, etc.)	lo-	Black, W	merican Indian, Vhite, etc.
	OO3	ed by	3 ☐ Widowed	4 ☐ Divorced		Year or Dates	:	16a Dece	1 ☐ Yes 2				16h	Specify: I	BLACK
!	:1215- within 72 ene. then "nat	Completed	(Spec	ify only highe	st grade co	on <i>mpleted)</i> College (1-4or	· F · \	(Give	e kind of wor DO NOT us	k done	during most of wo.	rking	100.1	Kind of Busine	as sylindustry
	2121 d within giene. er then	Com	10TH	indary (0-12)		College (1-40)	J+)	UNEM	PLOYE	D,				N/A	
•	tnd 2 be filed that Hygis of other	Be (	17. Father's Name								18. Mother's Nar			n Sumame)	
	aryland should be to nd Mental I marked o umatic eve	2				ON SLA	ADE	401-14-11		(2)		EZ GUZ			7.0.1
	Marylo		19a. Informant's Na		inip ( <i>Type</i> ,	MOT!	d F D		<sub>ing Address</sub> 1 Kav		and Number or Re				
	d a a E		20a. Method of Disp		/	HOII	20b.	Place of Disp	osition (Nam	e of		ALTO, MI	_	21206 Location - City	or Town, State
	Baltimore, permit. Pages 1 ar Department of Hea Importent: If Item: eny Injury or other		1 SyBurjal 2 4 Denation			oval from State	A.	cemetery, cre RBUTU:	S MEM	. F	PK. MAR	.8,200	6 F	BALTIM	MORE, MD.
:	Balti permit. Departn Imports ony Inju		21. Fature of Fu	ineral Service	Licensee	-//		2	2. Name and	Addre	ss of Facility SCRUGO			HOME	3
	m #9F # 9		23a. Part1. Enter the shock, or hea	ade	ne i	1.00	rug	1	412 E	• F	PRESTON	STREE!	r B	LTO,	D. 21213
	Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	(Final		GNSH Due to (or a	OT 1	MOUND					10 R		Approximate Interval Between Onset and Death
	ned insit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate rhying injury	<b>b</b> . –	Due to (or a	s a consec	quence of):			· · · · · · · ·				
	760, Ite be executed sysicien and ne burial-transit	<u>e</u>	resulting in death) I		d	Due to (or a	s a consec	quence of):							
	x 687	/Med	IF FEMALE:		220	If yes, outcom	o of progn	2001							
í	O. C. BOX 6  In the death certific  by the attending p  tached for use as	by Physician/Medic	23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ⊒No	250.	1 Live birth 4 Pregnant	2 ☐ Feta	al death 3	□Ectopic pre □ Other (spe		у			23d. Date of Month	Day Year
	ss tha	d by Ph	Part II. Other signif	icant condition	ons contrib	uting to death	but not res	sulting in the u	underlying ca	iuse giv	ven in Part I.				e to the cause of death?  Probably 4 Unknown
1	II Record The law require sate has been single 2 should I	Completed								-		per	opsy formed?	death	e autopsy findings available to completion of cause of 1?
	Vital F	Be Co	25. Was case refer	red to medica							26. Place of Dea	th (Check only		0 160	fes 2□ No
į	f Vita	ToB	examiner? 1 <b>XX</b> es 2□	No	Hosp	oital:	ient XI	¶ER/Outpatie	nt 3 DO	A Oth	000	lome 5□Res		6 □Other (S	Specify)
	On Of ding Ph. After th funeral	ü	27. Manner of Deat 1 □Natural	h 5 ⊡ Pendir		8a. Date of In (Month, D	ay Year)	28b. Time o	of 28	Sc. Injur Wor	y at rk?	28d. Describe			
	ISIO Mtendi death. ctor: A y the fu	cati	2 Accident	investi 6 🗆 Could	gation	2128/0		7:558			Yes 2 ⊠No				SHOT
30:	Divi	Certification;	4 Homicide	determ	nined 2	8e. Place of In building, e	etc. (Speci		reet, factory,	office		City or To	own. Stai	te)	Rural Route Number,
1	Hoep 4 hou Fune tely fil	Medical (	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physicia Examiner:	en: To the bes On the basis and manners	of examina	owledge, dear ation and/or in	th occurred anvestigation,	it the tin	me, date and place opinion, death occu	e, and due to the irred at the time	e cause( e, date ar	s) and manner nd place, and	r as stated. due to the cause(s)
`	To the within 2 To the comple	Me	29b. Signature and	title of certifie	r				29c.	Licens	se number		29d. D	ate signed (M	onth, Day, Year)
	. 3. 0		<b>)</b> ()	mas	) `					0.0	C.M.E.		Mar	ch 1,	2006
-			30. Name and addr				death (Ite			G:			ъл	1 1	21 201
			AN		UBic		and C'		Penn	Str	reet, Bal	timore,	Mar	-yrand	21201
	Sta Registr		31. Date filed (Mon	ih, Day, Year) IAR 0-6		32. Hegis	trar's Sign	acure	CAR!						

DHMH 17 Rev 1/2001

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ORIGINAL

			1 - For State o	f Marylan		artment o			ental Hygi	ene ()	06	064	86
9	, 364 y		Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day	Year	3. Time	of Death
100	Physici /Medic		William Robert Duff						February	28	2006	12:	00A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and nur	m <i>ber)</i>			m, or Location			4c. Co	unty of Deat		
			10822 Top Branch Lane 5. Social Security Number 6. Sex	7. Age (In yrs. I	last hirthday)	If Under 1 Y	Columbi	.a. or 24 Hrs.	8. Date of Birth		Howa		or Foreign
	Funeral Director		182-12-3972 1⊠M 2□F	89			ays Hours		Month, Day,	(ear) 1916	Pen	hplace (State buntry) nsylva	nia
	D.		Usual Residence of Decedent				1						
	show	7	10a. State 10b. County	10c. City	, Town or Lo							10d. Inside (	City Limits s 2 ☑ No
	the M	ecto	Maryland Howard  10e. Street and Number		C	Columbi			10	a Citizon	of What Co	l	
	3a or	Funeral Director	10822 Top Branch Lane				21044				S.A.	ound y :	
	death ms 2:	hera	11. Marital Status 12. Was Dece	edent Ever in U.	S. 13.			rigin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ame	nican Indian,	
9	after or Ita	/ Fu	Armed Fo 1 □ Never Married 2 ▼ Married 1 → Yes If Yes, Giv	2 No		ir res, specily 1 □ Yes 2 <b>∑</b>			nican, etc.)		Black, Whit		
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show he Madical Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Di	ates:							W	hite	
7	in 72 n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual O kind of work d DO NOT use ri	one during mo	st of working	ng 1	5b. Kina (	of Business/	industry	
212	d with giene.	шо	Elementary/Secondary (0-12) College (1 12 7	1-4or 5+)	Atto	rney				Chap	man, ]	Duff &	Pau1
b	al Hyg	Bec	17. Father's Name (First, Middle, Last)						(First, Middle, M		name)		
Maryland	should be filed within 72 hours after death with the Marylan nd Mental bygiene. Individed althygiene. Individed other than "natural", or Itema 23a or 28a-f show individed other than "natural" or indiffied all individed a	To	John T. Duff, Jr.						cine O'Ne				
Nar	N 40 00		19a. Informant's Name/Relationship (Type, Print)		1				Route Number,	•			<i>,</i> .
	other tr		Bernadine Duff (Wife) 20a. Method of Disposition	20b. P		sition (Name on atory or other			Columbia			Town, State	4
nor	Pages nent of int: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State		natory or other 's Ceme		3-4-2				ty, Ma	rvland
altimore,	표된 문문 등 .		21. Signature of Funeral Service Licensee	St.	22	. Name and A	ddress of Faci	ility					
m	Depa Impo any in		MSX. Haven	10	<u>\</u>	Jitzke 5555 Tw	Funera in Kno	Home	sad Incl	ımbia	, Mar	yland	21045
			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death	. Do not ent	er the mode of	dying, such a	s cardiac o	r respiratory arres	it,		Approxima Interval Be	etween
i Žias	Physician		Immediate Cause (Final disease or condition	Smal	lall	lung C	ancer					14 mos	
	/Medical Examiner		resulting in death)  Due to (	(or as a consequ		1							•
d		er		(or as a consequ	Jence of):								
N.	uted d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c.										
760,	ate be executed hysicien and the burial-transit			(or as a consequ	uence of):								
876	cate by physici the bu	dlcal	d										
9 X	The law requires that the death certifics tie has been signed by the attending phoage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23c. If yes, out	come of pregna	ncv					224	Date of del	ivos:	Å
Вох	death atter	clar	in the past 12 months?	oirth 2 Fetal nant at time of de	death 3	Ectopic pregn Other (specif				230.	Month	Day	Year
о. О	at the de by the a tached t	hys	9 □ Unknown 9□ Unknown	own									
ŝ	res that igned to be deta	by P	Part II. Other significant conditions contributing to de	eath but not resu	ulting in the u	nderlying caus	e given in Part	1.	23e. Did toba	_			- 1
ord	w require been signature	ted							1 X Yes	2 🗆 N	o 3∏Pr	obably 4	Unknown
Records,	The taw cate has b page 2 sl	Completed			-				24a. Was an autopsy perform		tb. Were au prior to death?	itopsy finding: completion of	s available cause of
a	iician: Th certificate rector, pag		(ac Wassers of Sand Sand Sand Sand Sand Sand Sand Sand						1 Yes 2	No	1 🗆 Yes	2 No	
<del>=</del>	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1  Yes 2 XNo Hospital: 1 1	Inpatient 2 🗆	ER/Outpatien	at 3□ DOA	Othor	oe of Death	(Check only one		Oth - 1 /C	-14.1	
Division of Vital	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of		28b. Time of Injury		Injury at Work?		8d. Describe hov			ciry)	
jo	Attending in death. ector: After by the fune	atlo	2 Accident investigation	in, Day rear	Injury		1 Yes 2	□No					
Ž	al or Attending P s after death. I Director: After t d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildir	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, of	fice	2	8f. Location (Stre City or Town,		um <i>ber</i> or Ru	ural Route Nu	nber,
	Hospital of the sale of the sa		29a. Certifier 1 Certifying Physician: To the	boot of my least	ula da a da ast								
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check only 2 Medical Examiner: On the ba	asis of examinat ner stated.	wiedge, death tion and/or inv	vestigation, in	ne time, date a my opinion, de	and place, a eath occurre	ind due to the cau ed at the time, dat	se(s) and e and pla	l manner as ce, and due	stated. to the cause	s)
	To the within To the compl	Me	29b. Signature and title of certifier	1		29c. Li	cense number		290	d. Date si	gned (Monti	h, Day, Year)	
			> Micheling Koveley	1 mes		D	38500	9	F	ebr	ua cu	282	006
	5+1		30. Name and address of person who completed caus	se of death (Item	23a) (Type,	Print)	. i Di	la. /	1. 1	1		1 2	1444
			31. Date filed (Month, Day, Year)	V65 LI	4410 1-	CETUVE	uct 1	19 (	ulumb!	us 1	recyle	ceno L	044
	Sta Registr		MAR 0 6 2006	ASSOCIATION OF THE PARTY OF THE	1	Se J			Elumbi				

			1 - For Stata Registrar	State of Mary		artment of I tificate of		Re	≥ UUU eg. No.	05487
	Physici		1. Decedent's Name (First, Middle, Last)  GEORGE KNIGH	Γ DASCH				2. Date of Deat Februar	y 28,2006°	3. Time of Death 10:05P M
	/Media Examir		4a. Facility Name (If not institution, give str The Wesley	eet and number)		•	or Location of Death		4c. County of Death	
10.05pm	Funeral Director		5. Social Security Number 6. Sex	7. Age (Ir	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, September	9. Birth 19, 1914 Ma	place (State or Foreign intry) ryland
-	aryland show	2	Usual Residence of Decedent  10a. State  10b. County	10	C. City, Town or Lo					10d. Inside City Limits
266	with the Marylar s or 28e-f show be notified at	Directo	Maryland N/A  10e. Street and Number  2211 West Rogers A	/onuo	Baltimore	10f. Zip Code	21209	1	Og. Citizen of What Cou	
2-282060	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland popartment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or othar treumatic event, the Madical Examinal must be mailfired at once.	by Funeral Director	_	. Was Decedent Eve Armed Forces? 1/2/Yes 2 □ No	rin U.S. 13. Y		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	, etc.
3.	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or any injury or other treumatic event, the Madical Exami		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educa	If Yes, Give Year or Dates:	16a Decec	ent's Usual Occu	nation	ing	Specify: Wh	
EXP	21215 od within 7 giene. er than "n	Be Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)		ute Owner			Newspape	r
reorge	yland  vuld be file Mental Hy arked oth attic event	To Be (	17. Father's Name (First, Middle, Last) George Elmer Dasch				l	Elizabe	eth Garrett	
Gec	Mary and 2 sho auth and 127 is m		19a. Informant's Name/Relationship (Type Elmer Dasch	, Print) Nephe		•			City or Town, State, Ziland 21013	p Code)
H	Pages 1: Pages 1: nent of He snt: If itan		20a. Method of Disposition  A Burial 2 □ Cremation 3 □ Rer  ↑ □ Donation 5 □ Other (Specify)	noval from State	orraine F	natory or other pla Park Ceme	etery 3/3/	′06	Baltimore,	Maryland
DASCH,	Balti permit. Departr Imports any inji		21 signature of Funeral Service Licery ee	naker	22	. Name and Addre			defeld Funeral imore, Marylar	
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease of complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury	tions that caused the cause on each line.  FND STA  Due to (or as a co	Onsequence of):	er the mode of dyi		or respiratory arre	sst,	Approximate Interval Between Onset and Death
	8760, cate be executed physician and the burial-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a co	onsequence of):					
	Box 6 auth certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delik Month	very Day Year
	cords, P.( w requires that the second signed by should be detact	by	Part II. Other significant conditions contri	buting to death but n	ot resulting in the ur	nderlying cause gr	ven in Part I.	23e. Did tob	eacco use contribute to	the cause of death?
	Division of Vital Records, P.O. to Attending Physicien: The law requires that the dafter death.  Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached	Completed						24a. Was an autops perform	24b. Were aut prior to co death? 1 \( \sum \) Yes	opsy findings available ompletion of cause of
,	of Vital F Physicien: Th this certificate al director, pag	To Be	1 Yes 2 No		2 ER/Outpatien	t 3 DOA	26. Place of Death ner: 4 Nursing Ho		e) nce 6 □Other <i>(Spe</i> c	fy)
	ision o ttending Pt death. stor: After th		2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of ear) Injury	28c. Inju Wo M 1	Yes 2 □No		w injury occurred	
P	Division of Vital Re To the Hospital or Attending Physicien: The Wilhin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Rui , State)	al Route Number,
20	he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier 1  Certifying Physic (Check only one) 2  Medical Examine		amination and/or inv	restigation, in my	opinion, death occuri		use(s) and manner as ate and place, and due	
	To t Withi To t	Σ	29b. Signature and title of certifier  Authorities	NO		29c. Licen:	se number 16619		9d. Date signed (Month March 1)	
			30. Name and address of person who com  C. VERGARA - SOARA		n (Item 23a) (Type, W ROGE	Drint)			no. 21209	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 6 200	32. gistrar's	Signature	make				

			1 - For State Ragistrar	State of M	/larylar			nt of H		and M		giene Reg. No.	106	06488
A.			1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		EVA				F0X				MARCH	1	2006	2:30 P M
	Examir		4a. Facility Name (If not institution, give		r)		4b. Cit	y, Town, or			=	4c. C	ounty of Dea	
		367 <sup>th</sup>	8911 REISTERSTO			In a bind to b	It I Ind	er 1 Year	P1k	(ESV				BALTIMORE
	Funeral Director		5. Social Security Number 6. S 219-30-5053	00 × 1 □ M 2 ☑ F   7. F	ige (in yrs. 9	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bird NOV . 25	1912	9. Bir	thplace (State or Foreign ountry) MD
	W		Usual Residence of Decedent					1 1				,		
	arylar show	<b>L</b>	10a. State 10b. County	5-	10c. Cit	ty, Town or Lo								10d. Inside City Limits
	th with the Marylan 23a or 28a-1 show	Director	MD BALTIMO	KE		PIKE								1 □ Yes 2 No
	with a	급	10e. Street and Number 8911 REISTERSTOW	N DOAD			101. 2	ip Code	212	กร		10g. Citize	en of What Co	USA
	ns 23	Funeral	11. Marital Status	12. Was Deceder	t Ever in U	.S. 13. \	Was Dec	edent of His			ecify Yes or No	- 14	1. Race - Ame	
9	or Iter	Ē	1 Never Married 2 Married	Armed Forces	? No	1	_			, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	
21215-0036	172 hours after death with the Maryland "natural", or Items 23a or 28a-1 show Idical Examinational Demotified at	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates	:			2 💢 No	Specify:			5	Specify:	WHITE
<u>7</u>	72	lete	15. Decedent's E (Specify only highest gra	ducation ade <i>completed)</i>		(Give	kind of w	ual Occupa vork done di use retired)	urina most	of worki	n <i>g</i>	16b. Kind	d of Business	/Industry
12	3 6 # 3	Completed	Elementary/Secondary (0-12)	Coltege (1-4o	r 5+)	OWNE		030 1011100)						RETAIL
b	othe	BeC	17. Father's Name (First, Middle, Last,	)					18. Mothe	r's Name	(First, Middle,	Maiden S	umame)	
/lar		To E	BENJAMIN			KAPL	AN		CLA	\RA				OBERMAN
Maryland	S D E E		19a. Informant's Name/Relationship (	,, ,			_				l Route Numbe			
	s 1 and 2 if Health a item 27 ls		LIBBY BISHOP / N 20a. Method of Disposition	IECE	20h F	1020 Place of Dispo			HIKE		Date		CITY,	MD 21042
JO.	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐		е С	emetery, crem INGTON	natory or	other place	1				ALTIMO	
Baltimore,			4 □Donation 5 □Other (Specifical Service Licentifications)		ANL				1		LEVINS			•
Ä	permit. Departimporti		Mydrae ?	Bruser										MD 21208
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one tause on each	ed the deat line.	h. Do not ent	er the mo	ode of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lever	e a	Aste	ć,	st	eno	عد				Onset and Death
3 <del>4</del>	/Medical Examiner		resulting in death)	Due to (or a	s a conseq									
. 6		-	Sequentially list conditions,	b. Due to (or a	s a consed	uence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,,.								
ó	an an rial-tr		resulting in death) Last	Due to (or a	s a conseq	uence of):								
8760,	cate be executed physician and the burial-transit	dlcal	•	d										
<u>ق</u> ×	leath certific attending p	Mec	IF FEMALE:	020 14										
Вох	eath cattendattend	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom  1 Live birth  4 Pregnant	2 Feta	Ideath 3	Ectopic (	pregnancy				23	d. Date of dei Month	ivery Day Year
P.O.	that the de ed by the detached	Physician/Me	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9 Unknown	at time of a	J_	) Other (s	spacity)						
<u>ر</u> ر	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Pi	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the ur	nderlying	cause give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
rds	w require been sig should b	ed t									101	es 2	No 3□Pr	obably 4 Unknown
ပ္ပ	has be	Completed									24a. Was		24b. Were at	itopsy findings available completion of cause of
<u>~</u>		Con									perfo	rmed?	death?	2□ No
Zii.	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				1 -			(Check only o			
ō	Phys rthis ral dii	.: To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of In	iurv	ER/Outpatien 28b. Time of	t 3 🗆 🗅	Other	4 🗀 Nui		ne 5 Resid		☐Other (Spe	cify)
on	Attending r death. sctor: After by the fune	atlor	1- Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	м	Work?	? es 2 □ N					
Division of Vital Records,	ar deg	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Ir	njury - At ho	ome, farm, stre	et, facto	ry, office		1	28f. Location (S City or Tow	Street and I	Number or Ri	ural Route Number.
ō	Itel or ins afte ral Dir led in I													
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the bes niner: On the basis and manners	ot examina	wledge, death tion and/or inv	occurre estigatio	d at the time n, in my opi	e, date and inion, deat	i place, a h occurr	and due to the ded at the time, o	cause(s) ar	nd manner as lace, and due	stated. to the cause(s)
	within To the compl	Me	29b. Signature and title of certifier				29	9c. License	number		./	29d. Date	signed (Mont	h, Dey, Year)
			) Jmn	Leonan	, m			1) 2	79	0	4	3-	2-0	6
			30. Name and address of person who			1 23a) (Type, I	Print)	200	E4.	1 200	201	¥ 20	0	
74			31. Date Med (Month, Gay, Year)	NEWN 32. Begis	trar's Signa	MLD,	10	633	MAL	<b>〜)</b> ~ <i>1/1</i> 7	HEW.	VIL	LE 1	21093
	Sta Registr	_	MAIN U 6 2006	OZ. Hegis	S Gigila	Acces!	<sub>2</sub> B		-	- 0 1				21073

			1 - For State Registrar	State of Marylan		artment of H			iene 0 0 6	06489
	Physici		1. Decedent's Name (First, Middle, Last) DONALD TIEM	EYER FREY				2. Date of Deat Ma Month	2 Day 2006 Year	3. Time of Death 3:00A M
	/Medio Examir		4a. Facility Name (If not institution, give s Suburban Hospital 5. Social Security Number 6. Sex	treet and number)	last hirthday)	4b. City, Town, or Bethes	da		4c. County of Death	ery
	Funeral Director		217-14-2268	M 2□F 88	Yrs.	Months Days	Hours Min		,1917 Mary	place (State or Foreign ntry) land
	a-f ehow	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A		y, Town or Lo					10d. Inside City Limits
	with the	i Dire	10e. Street and Number 113 Croydon Road			10f. Zip Code 2121	2	10	ng. Citizen of What Cou	ntry?
336	urs after deeth ai', or Itama 23 Xaminar mus	by Funeral Director		2. Was Decedent Ever in U Amed Forces? WZYes 2 □ No WW If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba		Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturei; or Itama 23a or 28a-f show any njury or other traumatic event, the Madical Examinar must be notified at ance.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+) 5+	(Give life. i	dent's Usual Occupa kind of work done of DO NOT use retired	fu <i>ring</i> most of wo	orking	Medical	ndustry
and	ild be filed lental Hyg ked other ilc event,	To Be C	17. Father's Name (First, Middle, Last)  Edward Leonard Fre	) Y				me (First, Middle, A	Maiden Sumame)	
Mary	nd 2 shou ilth and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type Carol Frey Clark	DTR			and Number or R	ural Route Number,	City or Town, State, Zi	
Baltimore,	Pages 1 au ent of Hea nt: if item y or othe		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo	sition (Name of natory or other plac ley Memoria	a)	Date 2	Coc. Location - City or Timonium, Mary	own, State
Baltir	permit. P Departme Importan any njur		21 ignature of Funeral Service License				s of Facility Mi	tchell-Wiede	efeld Funeral timore, Maryl	Hame Inc
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	SYSTOLIC	HE				est,	Approximate Interval Between Onset and Death
8760,	Examine be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a) consequence to (or a)	y AE uence of):	TERY	DISEAS	E	2	2 months
P.O. Box 6	Physician: The law requires thet the death certific this certificate has been signed by the attending print director, page 2 should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Bc. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	signed by	d by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	ın in Part I.	23e. Did tob	acco use contribute to s	
I Recor	: The law requires t cate has been signe page 2 should be	Complete	ANOYIC ENCE	PHALOPATI	44			24a. Was ar autops perform 1  Yes 2	24b. Were auto prior to co death?	opsy findings available impletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner?  1  Yes	ospital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Work	or: 4 🗆 Nursing i	Home 5 Reside	nce 6 Other (Speci	(y)
Divis	al or Atter after dea i Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number or Run , State)	al Route Number,
j	Hospital or 24 hours afte     Funeral Dir letely filled in I	edicai C	29a. Certifier 1 Cartifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the time restigation, in my of	e, date and place pinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as site and place, and due t	stated. the cause(s)
1	To the To the complet	Me	29b. Signature and title of certifier	le MD		29c. License	number		0d. Date signed (Month, 03/02/2)	• •
1	)		30. Name and address of person who con	mpleted cause of death (Item MD 1400	23a) (Type.	Print) GLEN R	#200	SILVER	SPRING, N	13 ZO910
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 6 700	32. Agistrar's Signa	ture	sells.		/		

ORIGINAL

			1 - For State Registrar	State of M	aryland		artment <i>tificate</i>			and M	ental Hy	giene Reg. No		)	06490
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Curtis Robert Ga								2. Date of D Month Februa	ath		66	3. Time of Death 9:00P M
	Examir		4a. Facility Name (If not institution, give Rebecca House	street and number)			_ `	Town, or Omac	Location o	of Death			. County of ontgo		7
	Funeral Director		5. Social Security Number 6. Sec 249-32-3287	7. Ag	je (In yrs. Ia 79		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Sept I	z, 19	26	Coun	lace (State or Foreign try) Ch Carolina
	Maryland a-f show	tor	10a. State 10b. County MD Montgome	ery		Town or Lo		ing						10	0d. Inside City Limits
	h with the 23a or 284	al Director	10e. Street and Number 1712 Merrifields	Drive			10f. Zip	Code 2090	)6				izen of Wh		•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 Is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic svant, If a Modical Expirition must be notified at once.	by Funeral	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 Yes 2 If Yes, Give Year or Dates:		1	Vas Deceder Yes, speci	ent of His		gi <i>n</i> ? (Spe i, Puerto f	cify Yes or N Rican, etc.)		14. Race -	America White, 6	an Indian, etc.
21215-0036	I within 72 ho iene. r than "natur the Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		5+)		ent's Usual kind of work OO NOT use	k done d e retired)	uring most )	of working	ng		ind of Busin		ernment
Maryland 2	uld be filed Vental Hyg Irked othar Itic svant,	To Be C	17. Father's Name (First, Middle, Last)  Luther Edward Gat				TILOL	riciric	18. Mothe		(First, Middle				timent
	and 2 sho salth and N n 27 Is ma ar trauma		19a. Informant's Name/Relationship (Ty Doug Gatlin (Son)	рө, Print)							Route Numb				Code) 20906
altimore,	Pages 1 Iment of He tant: If itan jury or oth	1 8	20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from State	ce		lge Me	her place	ial  P	ark :	ate 3/4/06	E1)		e, M	Maryland
Bal	Depar Impor any in		21. Signature of Fugeral Service Licens		d the death	1/2	50 Wa	<u>ısnır</u>	ngton	$_{ m BLV}$	eral H	crido	ge, Mi	, In	075
N.	Physician /Medical Examiner		23a. Part1. Enter the displace, or complishock, or heart failtire. List only or Immediate Cause (Final disease or condition resulting in death)		1050	lero		_			DiSE			4	Approximate Interval Batween Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as											
.O. Box 68	death certi e attending id for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spe						23d. Date o Mo <i>n</i> th		ry Day Year
٥.	.= W 75	2	Part II. Other significant conditions cor	tributing to death b	ut not resul	ting in the un	derlying ca	use give	n in Part I.				use contribu		e cause of death?
al Records,		Completed						-			24a. Was auto perfo 1 🗆 Yes		prio	ir to com	psy findings available apletion of cause of
Division of Vital	Attending Physician: The strates. The death. sctor: After this certificate by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1  Yes  2 No  H  27. Manner of Death 1  Accident investigation 3  Suicide  6 Could not be	ospital: 1  Inpatie 28a. Date of Inju (Month, Da	ry y Year)	R/Outpatient 28b. Time of Injury	28 M	c. Injury Work 1  Y	r: 4 □ Nur at	rsing Hom 2	(Check only one 5 ☐ Resi	dence (	y occurred		Assisted
DIX	크림		4 Homicide determined	28e. Place of Injuding, etc.	c. (Specify)						City or To	wn, State	)		Route Number,
	To tha Hospital within 24 hours a To the Funaral completely filled	Medical	29a. Certifier (Check only one)  1	ner: On the best and manner sta	examination	ledge, death on and/or inv	estigation, i	t the time in my opi	inion, deat	d place, a h occurre	nd due to the d at the time,	date and	and manne place, and e signed (A	due to	the cause(s)
l	V		Lobet/	Tre ,	M.O	2201/75 7		0		31	7	200. Dal		106	3.
	1		30. Name and address of person who as Robert F. By 31. Date filed (Month, Day, Year)	mpleted cause of d が このこの M. が 2. Registra	D.	233		NAS	1 51	. ,	ALLIN	1670	N, U	A	22202
•	Sta Registr		MAR 0 6 2006	A Carlos	A.	2004	-								

State of Maryland / Department of Health and Mental Hygiene () 116491 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 **Physician** MARCH 1, BARBARA GELMAN 11:51 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. (Month, Day Year) AUG. 3, 1956 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F Months Director 212-70-6855 49 MD Usuat Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Mudical Examiner must be notified at 1 √ Yes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 6638 EBERLE DRIVE #202 21215 USA or itams 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Hygiene. Black White etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, If all once. DEMONSTRATOR RETAIL - SAM'S CLUB 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) BERNARD GELMAN MIRIAM HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM GELMAN / MOTHER 6638 EBERLE DRIVE #202 - BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) BETH ISAAC ADATH ISRAEL 3/3/2006 DUNDALK, MD 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part1, Enter the disease, or combligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pulmonary ossible minutes /Medical Examiner Gilateral recent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Metastatic adenocaccinoma of breast to bones Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Lamobility 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? of Vital 2 No 1 ☐ Yes 2 ☐ No Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No Yes 2 No 1 Inpatient 2 N ER/Outpatient 3 □ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined To the Hospitel or Atte within 24 hours after de To the Funarel Directo completely filled in by the 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo D 35844 March 02, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 108 Randallstown MD 4300 Old Court Road Roggen 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State MAR 0 6 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month
March 2, 2006

Peath 4c. County of Death Month Dey Physician MARY ELEANOR FLECKENSCHILDT HURLEY 2:15PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner KESWICK HOME Baltimore City N/AB. Date of Birth (Month, Day, Year)
July 2, 1914 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country)
 Maryland 6 Sex 7. Age (In vrs. lest birthday) **Funeral** Days Months 1□ M 2X) F Director 91 212-36-5303 Usuel Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No **Funeral Director** Baltimore City 7 is marked other than "natural", or items 23s or 28s-f traumatic event, the Medical Examiner must be notific Maryland N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 700 West 40th Street 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 17 No Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Be Completed by Specify: USA 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secondary Teacher Education 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Charles Fleckenschildt 19a. Informant's Name/Relationship (Type, Print) Mary Loretta Bardroff 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 11 Monroe Field Court, Catonsville, Maryland 21228 Ann Hurleypalmer (Daughter) other 1 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Department if Important: if any Injury or 3/3/2006 Catonsville, Maryland Metro Crematory, Inc. 21. Signature Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical ears Examiner Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner Physicien: The law requires that the death certificate ba axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Arshritis 1 ☐ Yes 2 No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? betes Mellitus 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this eral Director: After thi fillad in by tha funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred i or Attending Faftar death. 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C
completely fillad 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Yeer) 29c. License number an 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Charles St. Bolts Md 21204 6701

**DHMH 16 Rev 6/95** 

State

Registrar

egistrer's Signatura

2006

			1 - For State Registrar	State of Maryland /	Department of Hea Certificate of De	ath	giene () () ()	06493
	Dhysisi		1. Decedent's Name (First, Middle, Last	t)	,	2. Date of De	ath Day Year	3. Time of Death
	Physici /Medio		IRENE	M. Holbroo.		February	128, 2006	520 AM
	Examir	ner	4a. Facility Name (If not institution, give	1 . 1/	4b. City, Town, or Loca	ation of Death	4c. County of Death	
			5. Social Security Number 6. Se	1030NIC HOME	1.004	Jnder 24 His. 8. Date of Birt		more
	Funeral Director			M 20 8 6	Months Days Ho	ours Min. (Month, Da	y, Year) Cou	place (State or Foreign intry)
			Usual Residence of Decedent			LUNCZ	2,1418	VVa.
	arylar show	_	10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits
2	88-1-8	Director		imore Du	wdalk			1 ☐ Yes 2 ☑ No
3	burs after death with the Marylar rat; or Items 23e or 28e-1 show		10e. Street and Number	0 1	10f. Zip Code		10g. Citizen of What Cou	
The state of	eath rs 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	2 / 2 2		. 14. Race - Ameri	
1 6	fer d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	Black, White,	etc.
#/ 2-00-5	72 hours after death with the Maryland 72 hours of tems 23e or 28e-f show disal Examiner must be mailfied at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Sp	pecify:	Specify: W/	ute
, 4	72 hours	Completed	15. Decedent's Edu (Specify only highest grad		ia. Decedent's Usual Occupation (Give kind of work done during	g most of working	16b. Kind of Business/Ir	idustry
4 5		ldш	Elementary/Secondary (0-12)	College (1-4or 5+)	life. 90 NOT use retired)		2011/1	'Lane
	* * * * * * * * * * * * * * * * * * *		17. Father's Name (First, Middle, Last)		Home maker	Mother's Name (First, Middle,	OWN F	TOTTIC
<i>w</i> = 20	y land build be filed Mental Hyg arked otha atic event,	o Be	Toh. 411		1	11 . 11 .	1.1.	
- 3	d 2 should be the and Menta Menta 7 is marked traumatic every	ဥ	19a. Informant's Name/Relationship (T)	ype, Print) 1!	9b. Mailing Addr ss (Street and N		KKI WEN er, City or Town, State, Zij	o Code)
			Luxleve M. FRA	Ne K-Daughter	8241 Delha	Ven Road. D	whalk no	À 2/222
77	es 1 and of Healt fitam 2		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Como	of Disposition (Name of tery, crematory or other place)	Date	20c. Location - City or To	-
, <u>È</u>	Page ment o ent: If		'4 □ Donation 5 □ Other (Specify)		LAWN Come lens	13/3/06	Dath more	, na
	permit. Pag Department Importent: any injury c		21. Signature of Funeral Service Licens		22 Name and Address of	cility for Funer	eal Home;	D.A.
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			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	one cause on each line.		· · · ·		Approximate Interval Between Onset and Death
	Pnysician /Medical	H	Immediate Cause (Final disease or condition resulting in death)	a. HOUTE CAR	Diovascular	went		
	Examiner			Due to (or as a consequence	Diovascularle	Disease		
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequenc	e of):	~ Viscore		
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.				
_	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequence	e of):			
8760	9 g E E	Physician/Medical		d				
~ ~ ~	leath certific attending p	Med	IF FEMALE:	200 If was automos of annual and				
Š	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver	ery Day Year
	at the de by the	ysic	1 ☐ Yes 2 DNo 9 ☐ Unknown	9☐ Unknown	5 Uther (specify)			
Δ	res that signed by be deta		Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause given in I	Part I. 23e. Did to	bacco use contribute to the	he cause of death?
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Ş	law require as been si 2 should t	plet	Valvulen her	ut disease, a	urtu Stein	24a. Was a		ppsy findings available
ă	The lav	Completed	Carolina atra	nli			rmed?, death? 2. No 1 ☐ Yes	mpletion of cause of
<u>;</u>	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	<i>p</i> /		Place of Death (Check only or		
7	Physic this co	2	1 ☐ Yes 2 📉 Vo	Hospital: 1 ☐ Inpatient 2 ☐ ER/C		X Nursing Home 5 ☐ Resid		y)
2	itending Phy death. Stor: After this / the funeral c	lon:	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Injury 28b (Month, Day Year)	. Time of 28c. Injury at Work?  M 1 ☐ Yes		now injury occurred	
Olivicion of Vital Becords DO	l or Attending after death. Diractor: After	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,			Street and Number or Rura	al Route Number
\$ \frac{1}{2}	spital or At ours after of teral Dirac filled in by	erti	4 Homicide determined	building, etc. (Specify)	and the soft matery, embe	City or Tow	n, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
V	Hospital or thours afte Funeral Directly filled in the		29a. Certifier 1 Certifying Phys	sician: To the best of my knowled	ge, death occurred at the time, da	ate and place, and due to the c	cause(s) and manner as s	tated.
**	To tha Hospital within 24 hours a To the Funeral I completely filled	edical	one)	iner: On the basis of examination a and manner stated.	and/or investigation, in my opinion	n, death occurred at the time, o	tate and place, and due to	) the cause(s)
	To tha within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License num		29d. Date signed (Month,	
			R.T. LiBert	<del></del>	12146	X	2-28-06	
			30. Name and address of person who co	ompleted cause of death (Item 23a Lv. MP . 3709	) (Type, Print)		123.7	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	voma 11 Be	alto, mil 2	1009	
	Registr	-	MAR 0 6 700	is A	Agrica 2			

		1 - State Registrar				tificate			Mental Hy	Reg. N	UUD	06494
Physic /Med		1. Decedent's Name <i>(First, Middl</i> e,  Charles Hurtt							2. Date of D Month Februs	D	ay Year 27 2001	3. Time of Death
Exami	Â.	4a. Facility Name (If not institution,  ST · AGN & S  5. Social Security Number	HOSPIT	AL	last birthday)	-	ILTI	MORU MORU Under 24 Hrs	5		c. County of Dea	
Funeral Director		212–56–9576 Usual Residence of Decedent	18 M 2□F	53	Yrs.	Months		Hours Min		952		rthplace (State or Foreig ountry) yland
Maryland	tor	10a. State 10b. County	<b>J</b> A	10c. Ci	ty, Town or Loc	cation Saltimo	re					10d. Inside City Limit
h with the 23a or 284	Funeral Director	10e. Street and Number 701 Arlington Avenu	ne Apt 309			10f. Zip	Code 1217			10g. C	itizen of What C	ountry?
72 hours after death with the Maryland "natural", or Itama 23a or 28a-f show idical Examinar must be notified at	þ	11. Marital Status  1 X Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces ad 1 Tyes 2 X If Yes, Give Year or Dates	? No	if f	Vas Decede Yes, speci	fy Cuban,	anic Origin? (S Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Am Black, Whi	
within ene. then "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 5	Education grade completed) College (1-4or	5+)	life. D	ent's Usual kind of work OO NDT use ttenda	k done duri e retired)	on ing most of wo	rking	16b. F	(ind of Business	
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s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationshi Eldora Hurtt / Stepu		20h F		Ashbu	rton S		ural Route Numb ltimore, I Date	MD 21	216	•
Page ment o ent: If ury or		1  Burial 2  Cremation 3 4  Donation 5  Other (Spe	ecify)	• _ ′	den Park	atory or oth	her place)	03-0			imore, MD	
permit. Depart Import any inj		1/100	22	,	Wy		neral 1	Home 638	N. Gilmon		Balto, M	D 21217
Physician /Medical Examiner		23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nily one cause on each  a. META.  Due to (or a:	STA	TIC C							Approximate Interval Between Onset and Death 2 YCCYS
ficate be executed physician and s the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as									
death certine attending of for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	I death 3 □I	Ectopic pre Other (s <i>pe</i>					23d. Date of de Month	livery Day Year
law requires that the as been signed by th 2 should be detache	b	Part II. Other significant condition	s contributing to death	but not res	ulting in the un	derlying car	use given ii	n Part I.				the cause of death?
The ite h	Completed					-			24a. Was auto perfo 1  Yes		prior to death?	utopsy findings available completion of cause of 2 No
To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director, it	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigal	Hospital: npati 28a. Date of Inju (Month, Da	шту	ER/Outpatient 28b. Time of Injury		Other: c. Injury at Work?		ome 5 Resi	dence		cify)
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ne Hospi n 24 hour ne Funer bletely fill	edical	one)	Physician: To the best caminer: On the basis of and manner st	ated	tion and/or inve	estigation, i	n my opinio	on, death occu	rred at the time,	date and	d place, and due	to the cause(s)
To the within To the comp	W	29b. Signature and title of certifier  30. Name and address dependent of the certifier of t	o completed cause of a cy Si 29 h C	, M	D	29c.	License nu	o 6 2	9	29d. Da	te signed (Mont	7, Day, Year) 27 2006

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14 yistt, CHARLES

Milburn Henson 06-1512 AKG

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of Hertificate of E	ealth and N Death		enė 006	06495
Physi	ician	Decedent's Name (First, Middle, La	•				2. Date of Death Month	Dan Vana	3. Time of Death
/Med	dical	Milburn Joseph Henson			45 Oits Town and	10-10-1	March 1,		2:41 P M
Exam	niner	4a. Facility Name (If not institution, give			4b. City, Town, or I			4c. County of Death	
Funera	al		Sex 7. Age	(In yrs. last birthday)	Baltimore If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	n/a 9. Birth	place (State or Foreign intry)
Directo		219-82-9383	1 <b>X</b> M 2□ F	43 Yrs.	Months Days	Hours Min.	04-19-1963	B Mary1	
and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Maryl 1 eho	ō	MD NA			Baltimore				1 XYes 2 No
n the	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
th wit	E C	401 N. Eutaw Street	Apt 108		21201			USA	
tems	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces? 1 Yes 2 XNo	ver in U.S. 13. \	Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	pecify Yes or No-	14. Race - Amer Black, White	
hours after	by F	12 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		I□Yes 2XINo	Specify:		Specify:	_
2 hou		15. Decedent's E	ducation	16a. Dece	lent's Usual Occupat	ion	16	B1 6b. Kind of Business/Ir	ack
Prin 7	Completed	(Specify only highest gri	ade completed)  College (1-4or 5+	(Give	kind of work done du DO NOT use retired)	iring most of work	king		,
ed wi	S	12	4		Laborer			Constructio	n
ntai H ed oti	Be	17. Father's Name (First, Middle, Last Milburn J. Henson					e (First, Middle, Ma	aiden Sumame)	
hould Me mark	2	19a. Informant's Name/Relationship (		19h Mailin	n Address (Street ar		Mae Nixon	City or Town, State, Zi	a Cada)
If c, INICITY CLICIO-0050  It and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  Item 27 is marked other than "natural; or Items 23s or 28s-1 show other traumatic event, Ite Medical Examinet must be notified at		Teffany Horne/ Fianc			Eutaw Stre				p C009)
of Hee		20a. Method of Disposition		20b. Place of Dispo				oc. Location - City or T	own, State
Pages nent of 1		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr		Metro Crema		03-03-	06 (	Catonsville,	MD
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is		21. Signature of Funeral Service Lice	1500		Name and Address		N. Gilmor S	t. Baltimore	. MD 21217
		23a. Part1. Enter the disease of corr shock, or heart failure. List only	plications that caused the	ne death. Do not ente					Approximate
Physician	1	Immediate Cause (Final disease or condition	Gunshi	A.	ds(2) 0	f Hea	-d		Interval Between Onset and Death
/Medica Examine		resulting in death)	Due to (or as a	consequence of):					
Examine		Sequentially list conditions,	b	7150000000000000					
ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence vi).					
execu n and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a	consequence of);					
ate be executed only siclen and the burial-transit	dical		d						
rtifical ng phy as th	Medi	IE EENALE.							
ires that the death certific signed by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2		Ectopic pregnancy			23d. Date of deliv	,
the a	ysici	1 Yes 2 No	4∏Pregnant at tir 9□Unknown	me of death 5	Other (specify)			Month	Day Year
that the ed by detac		Part II. Other significant conditions of	ontributing to death but	not resulting in the un	deriving cause given	in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	d by				,	2000		V	pably 4 □Unknown
aw requires been si	Completed						24a. Was an	24b. Were auto	ppsy findings available
The la	E O				·		autopsy performe	d? prior to co	mpletion of cause of
	BeC	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes 2 h (Check only one)	No 1 X Yes	2 □ No
Attending Physician: The laving death.  •ctor: After this certificate has by the funeral director, page 2	은	1 ☑Yes 2 ☐ No	Hospital: 1 ☑ Inpatient			4 Li Nuising no		e 6 □Other (Speci	(y)
ding f	i o	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day )		28c. Injury a Work?		28d. Describe how		st
death ctor:	ficat	2 Accident investigation 3 Suicide 6 Could not b	3-1-00	11:43 A		s 2 No	28f Location (Street		
e effer e effer e Dire	Certification;	4 Homicide determined	building, etc.	(Specify)		elling	R . II	State) 1900 Ed	Imenson Aug
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Exar	ysician: To the best of niner: On the basis of e	my knowledge death	occurred at the time	date and place	and due to the caused at the time, date	so(s) and manner as s	tated.
o the i ithin 2 o the l	Med	one) 29b. Signature and title of certifier	and manner state	d.	29c. License r			. Date signed (Month,	
⊢ 3 ⊢ ŏ		1 4 5	nio						
		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, F		.C.M.E.		March 2, 2	.006
			O		nn Street	, Baltim	ore Maryl	and 21201	
	tate	31. Date filed (Month, Day, Year)	32. Registrar's	Cianatura					
Regis	uar	MAR 0 6 2	JUD ALASAG	Signature			_		

				partment of Health and Mertificate of Death	lental Hygie Reg.	F000 00470
L	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> William Hunter Sr.		2. Date of Death Month February	<sup>Day</sup> 28 2006 1:05P M
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give street and number)  Millennium @ South River  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)  224-32-4633   12 M 2 F   78 Yrs.	4b. City, Town, or Location of Death  Edgewater  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug 30	Anne Arundel  9. Birthplace (State or Foreign Country) 1927 W. Virginia
	show	5	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Anne Arundel Annapo:		indig 00	10d. Inside City Limits
	death with the Maryland time 23a or 28a-f show	Direc	Maryland Anne Arundel Annapo 10e. Street and Number 1993 West St.	10f. Zip Code 21401	10g.	1 √ Yes 2 □ No  Citizen of What Country?  USA
036	hours after deal tural', or items	by Funeral	I I Never Married 2 Married   1 XYes 2 I No	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black.
Maryland 21215-0036	within 72 ene. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of worki DO NOT use retired) Alley Worker	ing	b. Kind of Business/Industry
land 2	ould be filed Mental Hygid arked other atic event, I	To Be Co	6th 0 Ga 17. Father's Name (First, Middle, Last) Will Hunter	18. Mother's Name	U. (First, Middle, Maid Moorman	S. Naval Academy
_	od 2 g		Doris Hunter(Daughter) 857	ing Address (Street and Number or Rura Derby Farms Dr.	Severn	, Md. 21144
Baltimore,	permit. Pages 1 ar Department of Hea Important: if Item; any injury or other ance.		4 Donation 5 Other (Specify)	natory or other place) d Veteran 3-6-	06 Cr	COWNSVILLE, Md.
eg T	Depri Depri Impo		Jarry J., Rees Moo 483  23a. Part. Enter the disease, or complications that caused the death. Do not en	Name and Address of Eacility Ons M. Reese & Sons 21 West St. Ann ter the mode of dying, such as cardiac o	apolis,	Md. 21401
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	CANCER		Interval Between Onset and Death
	ifficate be executed xx g physician and as the burial-transit as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	BSPROUTIVE P	DUMONIAR	Y WISENSE
DOX	ath certif	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
cords, r	equires that en signed b ould be deta	ρ	Part II. Other significent conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
משר ופי	n: The law r ficate has be or, page 2 sh	e Completed	OF Was and other days of the state of the st		24a. Was an autopsy performed?	
		To B	25. Was case referred to medical examiner?  1   Yes   2   No			6 ☐ Other (Specify) jury occurred
Ž	pital or Atti burs after de eral Directo	i Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street building, etc. (Specify)  29a. Certifier  14 Certifying Physician: To the best of my knowledge death		City or Town, Sta	
	ro the Hos within 24 ho Fo the Fun completely	Medical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant manner stated.	occurred at the time, date and place, at vestigation, in my opinion, death occurre  29g. License number	od at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s) Date signed (Month, Day, Year)
	2,50		30. Name and address of person who completed cause of death (Item 23a) (Type, I	D57313		3/2/6
2	Stat Registra	~	31. Date filed (Month, Day, Year)  32. Registrar's Signature	LINDEN A	E BA	NTIMORE 2124

State of Maryland / Department of Health and Mental Hygiene [] [] [ For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DARIUS M. **JONES** February 2006 1125 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1521 Ray Road #303 Prince George's Hyattsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X**M 2□ F Yrs. Director Aug. 20, 1969 Wash.,DC 36 577-13-0999 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examinar must be notified at 1X Yes 2 ☐ No Director DC Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 2025 3rd. Street, N.E. 20002 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if tiem 27 ie marked other than "natural", or item ony injury or other traumatic event, the Mental once. 1 ☐ Yes 2 Mar No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Holtel Worker Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Welcome Jones Sharon Jones ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2025 3rd. Street, N.E. Wash. DC 20002 ce of Disposition (Name of Date 20c. Location - City Welcome Jones/father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/10/06 Glenwood Cemetery Washington, D.C. 22. Name and Address of Facility
Frazier's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wash.,DC 20001 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gunshet Wounds(2) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the deeth certificate be executed ng physicien and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No autopsy performed? 1 Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XIX Yes 2 □ No Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) Scene မ this After this funeral c 28a. Date of Injury
(Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. i Director: A 2/3/06 1 Yes 2 No Subject Shot 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 1521 Ray Rd #303 Hyatts Ville MD 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter or to the Funeral Direct completely filled in by To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME February, 4, 2006 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 32 Régistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 0.6 2006

1384

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 5:15 PM 03 01 2006 Jackson C. Jones /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner oseda Baltimore DITA Hos Franklin Mare Year If Under 24 Hrs. 7. Age (n yrs. last birthday) 8. Date of Birth (Month, Day, Year) 0 / 2 / 4 0 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months Days 1₽¶M 2□ F Hours Tennessee 57 Yrs. 214-50-4489 Director Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow with jury or other traumatic event, the Madical Examinar must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Dundalk Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 7329 Manchester Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1. Never Married 2 ☐ Married Specify: White land 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Pauline Keene Jackson Claude Jones ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7329 Manchester Rd. Baltimore, Md. Nancy Orye / Sister Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3/6/06 Baltimore, Md. Raczorowskia Tuneral Home P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 21222 Cartne ugen implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part 1. Enter the disease, A Approximate Interval Between Onset and Death mmediate Cause (Final Preu monia Physician Wr.ek disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit law requires thet the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 PNo 3 Probably 4 Unknown icete has been sig , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was.an certificete has autópsy pérformed: 1 Nes 2 No 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division the Hospital or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 03/02/2006 Willes, MD 3666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Square Drive Baltimore, MD, 21237 Stuart Willes tranklin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 6 Agaret Registrar

Johnson

Physi /Med Exam

Funera Directo

	1 - State Registrar	tate of Maryland / I		t of Health e of Death			ienė	] (;	06500
ciar	1. Decedent's Name (First, Middle, Last)	Ι.		KOVLER		Date of Deat Month IARCH 1		Year	3. Time of Death 5:30 A M
lica inei	And Phone 10th and Administration of the Adm		4b. City,	Town, or Location		IAINOII I	4c. County	of Death	3.30 A
	HOSPICE OF BALTIMOR	E GILCHRIST CT	R.	T0	WSON			BALT	ΓIMORE
1	5. Social Security Number 6. Sex	7. Age (In yrs. last bit	rthday) If Under Yrs. Months	1 Year If Unde Days Hours	Min. 8	Date of Birth (Month, Day, APR . 19	Year)	9. Birthpl Count	ace (State or Foreign
r	Usual Residence of Decedent	95	113.			APR. 19	,1910		"' NY
.	10a. State 10b. County	10c. City, Tow	m or Location					10	od. Inside City Limits
100	MD BALTIMOR	RE	BALTIMOR						1 ☐ Yes 2 🕅 No
2	10e. Street and Number		10f. Zip		1207	1	0g. Citizen of V		try?
Completed by Funeral Director	3304 CROYDON ROAD  11. Marital Status 12.	Was Decedent Ever in U.S.	13. Was Deced	dent of Hispanic Or off Cuban, Mexica		y Yes or No-		e - America	an Indian,
ū	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				can, etc.)		ck, White, e	WHITE
1	3 X Widowed 4 □ Divorced		1 ☐ Yes		·		Specify		
date	15. Decedent's Educati (Specify only highest grade co	mpleted)	Give kind of wor Give NOT us	rk done during mo	st of working		16b. Kind of B	usiness/Ind	ustry
2	Elementary/Secondary (0-12)	College (1-4or 5+)	INSPECTO	R			MANUFA	CTURIN	NG
a	17. Father's Name (First, Middle, Last)					First, Middle, I	Maiden Suman	,	
F	BERNARD		KOVLER		TTA			<u>`</u>	JNKNOWN)
	19a. Informant's Name/Relationship (Type, KENNETH KOVLER / S		3304 CR0						Code)
	20a. Method of Disposition	20b. Place o	f Disposition (Nan	ne of	Date	_	20c. Location -		wn, State
	1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	iry, crematory`or o SINAI CEM		03/03/	2006	OWING	GS MIL	LS, MD
	21. Signature of Funeral Service Vidensee	Mari		d Address of Facil	ity SOL	LEVIN	SON & E		, INC. MD 21208
	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one	ous at caused the death. Do	not enter the mod	e of dying, such as	s cardiac or r	espiratory arre	est,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Acute or	NdiAc	ever	17-	prof	nsle		Onset and Death
	resulting in death)	Due to (or as a consequence	of):	1.0	Clar	5/10-1	`\a d\		
<u> </u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):	U (VIV	- 1	1000	- 0		Mind
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	И	nyoci	Ardinl	int	AVCTO	M		
Exa	resulting in death) Last	Due to (or as a consequence	of):						
dicai	d								
/We	IF FEMALE: 23c.	If yes, outcome of pregnancy				· · · · · ·	22d Do	te of delive	
Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pro 5 □ Other (spo						Day Year
V Ph	Part II. Other significant conditions contrib	uting to death but not resulting in	n the underlying ca	ause given in Part	l	23e. Did tob	acco use cont	ribute to th	e cause of death?
pa	End Stage	i) event.	a wil	4 5,20	litela	1 UY	s 2 No	3 ☐ Proba	abły 4 □Unknown
noiet	dysphagia,	H-perte	ension	, ,		24a. Was a autops	y	prior to con	osy findings available appletion of cause of
Ö	OF Was asso referred to medical						No	death? 1 🗆 Yes	2□ No
To Be		ital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DO	Othor	· ·	Check only on	e) Ince 6 Mar⊙th	or (Snacihi	Horace
		8a. Date of Injury 28b. 1		8c. Injury at Work?			w injury occur		110-6.6
catic	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐	]No				
Certification:	3 Suicide 6 Could not be 4 Homicide determined	<ol> <li>Place of Injury - At home, fa building, etc. (Specify)</li> </ol>	arm, street, factory	, office	28f	Location (St. City or Town	reet and Numb , State)	er or Rural	Route Number,
Medicai C	29a. Certifier Check only one) Certifying Physicial Examiner:	n: To the best of my knowledge On the basis of examination an	e, death occurred and/or investigation,	at the time, date a	nd place, and ath occurred	d due to the ca	use(s) and ma	anner as sta	ated. the cause(s)
Med	29b. Signature and title of certifier	and manner stated.	29c	. License number		2	9d. Date signe	d (Month, L	Day, Year)
	I M Hath	my flely.	no 1	1)250	de	1	MAN	2h 1	,2006
	30. Name and address of person who comp	eted cause of death (Item 23a)	(Type, Print)	N.CR	orle	51	Post	AD. 11	,2006 Nd 212dx
tate	31. Date filed (Month, Day, Year)	32. Segistrar's Signature	South			7/0	المال المال		21-9
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